

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER United Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 405 First Ave Brookings, SD 57006	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50915</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to protect one of two sampled resident (1) from physical and verbal abuse, and one of two sampled resident (2) from verbal abuse and involuntary seclusion by resident 3's spouse. Findings include:</p> <p>1. Review of the SD DOH FRI submitted on 6/15/24 at 7:35 p.m. revealed:</p> <p>*Registered nurse (RN) D reported that certified nurse aide (CNA) C witnessed resident 3's spouse wheeling resident 1 down the hall.</p> <p>*Resident 1 was holding his hand up as if he may have been attempting to grab resident 3's spouse.</p> <p>*In response to resident 1's action, resident 3's spouse hit [resident 1] over the head with her right hand.</p> <p>*RN D immediately assessed resident 1 and when asked if resident 3's spouse hit him, his response was that resident 3's spouse tried to hit him, and I blocked her.</p> <p>*RN D's physical assessment of resident 1 did not reveal any redness, bruising, or raised areas on resident 1's head.</p> <p>*Resident 1 then stated that resident 3's spouse did hit him on his temple, but not very hard.</p> <p>*During interview with resident, he did not show any fear of the situation.</p> <p>*RN D notified the facility administrator. Administrator will be in the facility to discuss the situation with [resident 3's spouse].</p> <p>*The report indicated that local law enforcement and the South Dakota Department of Human Services (DHS) were not notified.</p> <p>-Under the section Why or why not? for law enforcement notification, the report indicated, Administrator will be in facility in am [a.m.]</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Under the section Why or why not? for DHS notification, the report indicated, Notified Ombudsman via email.</p> <p>2. Observation on 6/24/24 at 5:15 p.m. in the South Ridge common area revealed:</p> <ul style="list-style-type: none"> *The common area consisted of the dining room and television room. *Residents were eating supper at the time. *Resident 1 was sitting at a table near the window. *Residents 2 and 3 were sitting at the same table. *Resident 3's spouse was sitting in a recliner in the television room. <p>*Interview at that time with resident 3's spouse revealed:</p> <ul style="list-style-type: none"> -She came to the facility twice per day, every day. -She helped resident 3 with lunch and supper and to get ready for bed each night. <p>3. Interview on 6/24/24 at 5:32 p.m. with administrator A regarding the FRI revealed:</p> <ul style="list-style-type: none"> *The incident happened on Saturday 6/15/24 around 6:30 p.m. *She was informed of the incident on 6/15/24 and instructed RN D to complete a state report. *Director of human resources (DHR) I and administrator A came to the facility on Sunday 6/16/24 and met with resident 3's spouse to discuss the incident. *Administrator A told resident 3's spouse that you can't move or touch other residents. *Resident 1 was interviewed several times on the evening of 6/15/24. -He was not a good historian. -One time he said that resident 3's spouse hit him, and another time he said that I blocked it. -He was not consistent with answering if he was hurt or not. *CNA C witnessed the incident and immediately informed RN D. *RN D immediately assessed resident 1 and found no injuries. *She confirmed that resident 3's spouse continued to assist resident 3 with his nighttime routine and left the building around 7:30 p.m. <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*He indicated the survey team could talk to my [spouse] when [they] get here, when asked about concerns with specific incidents.</p> <p>13. Interview on 6/25/24 at 4:17 p.m. with LPN K regarding the above incident revealed:</p> <p>*She was working 6/15/24 when the incident happened, but she did not witness the incident.</p> <p>*She was aware of the relationship between residents 1 and 2.</p> <p>-She said that resident 1 thinks it's funny, he pushes resident 2's buttons.</p> <p>*She said that staff were aware of their arguing and kept them separated.</p> <p>*She noted that resident 3's spouse was there every day. She is very dedicated. She does a good job with resident 3's care.</p> <p>*When asked if she knew of any other incidents between other residents and resident 3's spouse, she said that last year, there was a resident with dementia, and she snapped at him, nothing over the top.</p> <p>-See F610, finding 16.</p> <p>14. Interview on 6/25/24 at 4:53 p.m. with director of social services G regarding the above incident revealed:</p> <p>*Regarding the relationship between residents 1 and 2, she said, they periodically [NAME], staff usually intervene, and they are easy to redirect.</p> <p>*She said that there had never been physical aggression between them.</p> <p>*When asked if there had ever been a discussion about moving them to separate units, she revealed that resident 2 was recently moved to a room in a different hallway from resident 1.</p> <p>-She said that this has been helpful because they do not always see each other when they come out of their rooms.</p> <p>-Regarding moving one of them to a different unit, she said, you hate to uproot.</p> <p>*She said that resident 3's spouse is a consistent person in the building, visiting multiple times a day.</p> <p>*She was not aware of any previous physical aggression from resident 3's spouse. I've never seen that side of her.</p> <p>15. Interview on 6/25/24 at 5:24 p.m. with administrator A regarding the above incident revealed:</p> <p>*When asked if there were any other known incidents between resident 3's spouse and resident 1, she was not aware of a previous incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*She reviewed resident progress notes and was not able to find any information about any other incidents between resident 3's spouse and resident 1.</p> <p>16. Continued interview on 6/26/24 with administrator A regarding the above incident revealed:</p> <p>*The first step in the facility's investigation process when there was a complaint of potential abuse of a resident was to ensure resident safety.</p> <p>-RN D performed her assessment of resident 1 and notified administrator A.</p> <p>-RN D then had CNA C give a handwritten statement of what he had witnessed.</p> <p>-She asked RN D where resident 3's spouse was and was told that she was in the room with resident 3 helping him get ready for bed.</p> <p>-RN D completed the FRI that evening.</p> <p>-She said that she entered the facility at 8:00 a.m. the next morning and talked to resident 3's spouse, RN D, and the ombudsman.</p> <p>-She said that she asked the ombudsman if law enforcement needed to be notified, and the ombudsman did not tell her that it was required.</p> <p>-She said that resident 1 was asked if he wanted to call law enforcement regarding the incident and he did not.</p> <p>-When asked if there were any interviews of involved staff or residents and she said she had not. She felt that resident 3's spouse gave enough information about the incident, that there was no need to interview any other residents or staff.</p> <p>*She said that there had been increased education to staff regarding incident reporting.</p> <p>17. Phone interview on 6/26/24 at 9:48 a.m. with RN D regarding the above incident revealed:</p> <p>*She was unaware of any other incidents in which resident 3's spouse was verbally aggressive with other residents.</p> <p>*She said that she did hear from RN L that resident 3's spouse had spoken to resident 3 in an unpleasant manner before.</p> <p>18. Interview on 6/26/24 at 9:56 a.m. with RN M regarding the above incident revealed:</p> <p>*She was the case manager for the nursing home.</p> <p>*She revealed that resident 3's spouse was at the facility often.</p> <p>*She said that she was present for resident 3's senior psychological appointment in which resident 3's spouse voiced concerns that resident 3's roommate always has his TV volume very loud.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident when asked if he would like to press charges on the [visitor], he made the comment 'I want to make them pay, they took all my money I had saved up.'</p> <p>-Writer attempted to notify [resident's] daughter to notify her of the situation, however, when calling a recording comes across 'the person you are calling cannot take calls at this time, the number you have dialed is not answering, please try later.'</p> <p>-Administrator was notified of the situation and will be here tomorrow while the visitor is in the facility to take care of the situation.</p> <p>*A follow-up health status note entered on 6/16/24 at 1:10 a.m. read:</p> <p>-Resident has been monitored frequently this shift for any s/s [signs or symptoms] of distress related to recent incident early in the shift. Resident has been resting in bed with eyes closed. Has not shown any distress this part of the shift.</p> <p>*A follow-up health status note entered on 6/16/24 at 12:15 p.m. read:</p> <p>-Resident denies having any pain. Transfers per usual. Alert and out for meals. No bruising noted. Denies having any pain.</p> <p>*A social work note entered on 6/18/24 at 3:49 p.m. read:</p> <p>-[This] writer met with resident to follow up on recent incident involving another resident's family member hitting him on the head.</p> <p>-Writer and resident visited about this incident.</p> <p>-Resident initially did not recall the incident, however, was able to briefly state that he remembers 'that [person] that pushed me back to my room.'</p> <p>-Writer asked resident if he is fearful of this person and he said 'no.'</p> <p>-This writer asked resident if he feels safe at [facility] and he stated 'yes.'</p> <p>-Will continue to check in with resident.</p> <p>*There were no other follow-up notes regarding the incident between resident 1 and resident 3's spouse.</p> <p>21. Review of CNA C's handwritten statement revealed:</p> <p>*[Resident 1] and [resident 2] altercation led to [resident 3's spouse] wheeling [resident 1] back to his room.</p> <p>*While doing so, [resident 1] was holding up his right hand possibly trying to [grab] her.</p> <p>*In response, [resident 3's spouse] hit [resident 1] over the head with her right hand.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER United Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 405 First Ave Brookings, SD 57006	
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*It was hard enough to be clearly heard 20 feet back and led to a vocalization of pain from [resident 1].</p> <p>*[Resident 3's spouse] appeared to be angry about [resident 1] and [resident 2's] altercation.</p> <p>22. Review of staff schedules from the evening of 6/15/24 on the South Ridge unit revealed the following employees were on-site:</p> <p>*CNA C from 2:15 p.m. to 10:45 p.m.</p> <p>*CNA E from 2:15 p.m. to 9:00 p.m.</p> <p>*LPN K from 6:00 a.m. to 6:30 p.m.</p> <p>*RN D from 6:00 p.m. to 6:30 a.m.</p> <p>*Dietary aide F from 4:30 p.m. to 7:30 p.m.</p> <p>23. Review of resident 2's electronic medical record revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His medical diagnoses included: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified anxiety disorder, major depressive disorder, vascular dementia.</p> <p>*His most recent BIMS score from 4/10/24 was 13, which indicated he was cognitively intact.</p> <p>*A social work progress note entered on 6/18/24 at 2:16 p.m. read:</p> <p>-[This] writer met with resident to follow up on incident of him being wheeled into his room by other resident's family member.</p> <p>-Resident was able to recall this incident, but did not feel threatened by the family member and stated he does not feel fearful of her.</p> <p>-This writer asked resident if he feels safe at [facility] and he stated 'yes.'</p> <p>*There was no indication that the resident's wife, his responsible party, was notified of the incident.</p> <p>24. Review of resident 3's admission documentation revealed that his spouse signed the acknowledgement that they received a copy of the Residents' Rights document on 5/31/23.</p> <p>25. Review of the provider's March 2017 Acknowledgement of Resident Rights and Responsibilities policy revealed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Policy Statement: Each resident (or resident representative) will be provided and must acknowledge receipt of a written copy of resident rights and all rules, regulations, and policies governing the resident's conduct and responsibilities during his/her stay in the facility.</p> <p>*Policy Interpretation and Implementation:</p> <p>-1. Prior to or upon admission, a representative of the admitting office will give the resident, or the resident's representative, a written copy of resident rights and responsibilities, including facility rules, regulations, and policies governing the resident's conduct and responsibilities during his/her stay in the facility.</p> <p>-2. A representative from the business office or from social services will review the rights and responsibilities with the resident or the resident's representative. This review will occur as soon as possible within the first week of the individual's admission to the facility.</p> <p>-3. The resident, or the resident's substitute decision maker or representative, will be required to sign a statement acknowledging his/her receipt of a written copy of resident rights and responsibilities and that an oral review of such rights and responsibilities was conducted.</p> <p>-4. For individuals who have been formally declared incompetent or who cannot make decisions in accordance with this state's current laws, regulations, and guidelines, the resident's representative will be informed of the resident's rights and the representative will be entitled to act on the resident's behalf.</p> <p>-5. A representative of the administration or business office will inform residents orally and in writing of changes in federal or state regulations relative to resident rights or when changes in facility policy affects the rights or responsibilities of residents. Notices will be provided within 14 days of such change(s) taking effect.</p> <p>-6. Signed and dated copies of the resident's acknowledgement of rights and responsibilities and any subsequent revisions are maintained in the resident's medical record.</p> <p>26. Review of an email communication sent by RN M following resident 3's psychological appointment on 3/28/24 revealed:</p> <p>*RN M provided education to resident 3's spouse on resident rights.</p> <p>-Resident 3 and his spouse had been expressing feelings of frustration because they had been continually turning down resident 3's roommate's television because it was too loud.</p> <p>-RN M wrote, Please remind her that this is a violation of [roommate's] rights.</p> <p>27. Review of a Formal Grievance submitted by resident 3's spouse on 5/15/24 revealed:</p> <p>*Resident 3's spouse submitted a formal grievance to discuss the care that resident 3 was receiving.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Resident 3's spouse named a specific CNA in their grievance, stating that [I find] bruises on [resident 3] when [I come] to see [resident 3] in the morning.</p> <p>-Resident 3's spouse did not provide any specific situations, nor could she recall any.</p> <p>*Education was provided to [resident 3's spouse] regarding how [facility] investigates suspicious bruising and the importance of reporting these concerns when they happen so they can be properly investigated . Information provided regarding [facility's] zero tolerance for retaliation, specifically regarding incident reporting.</p> <p>*Education regarding policy on when/how police are called was given to [resident 3's spouse], specifically that [facility] would not call Police before attempting to contact [resident 3's spouse], with the only exception being imminent danger to staff or [resident 3].</p> <p>*[Resident 3's spouse] expressed verbal understanding .</p> <p>*Education regarding Resident Rights provided at this time.</p> <p>*Action Plan:</p> <p>-1. Monthly Care Conferences will be held with [resident 3's spouse], [director of social services G] and [DON B] to address any concerns and follow up on the Grievance action plan. These meetings will begin the week of June 17th, 2024, at [resident 3's spouse's] request.</p> <p>- 4. Education regarding Resident Rights will be given to [facility] staff at the next all staff meeting on May 28th, 2024.</p> <p>28. Review of the provider's undated Nursing Home Resident's Rights document revealed:</p> <p>*Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination. Many States also include residents' rights in state law or regulation.</p> <p>*Right to a Dignified Existence</p> <p>-Be treated with consideration, respect, and dignity, recognizing each resident's individuality.</p> <p>-Freedom from abuse, neglect, exploitation, and misappropriation of property .</p> <p>- .Quality of life in maintained or improved.</p> <p>-Exercise rights without interference, coercion, discrimination, or reprisal.</p> <p>-A homelike environment .</p> <p>-Equal access to quality care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>29. Review of the provider's February 2024 Abuse policy revealed:</p> <p>*Policy Statement: Each resident has the right to be free from abuse, neglect . This includes but is not limited to freedom from corporal punishment, involuntary seclusion . Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals.</p> <p>*Policy Explanation and Compliance Guidelines:</p> <p>-1. The Abuse coordinator in the facility is the Director of Nursing, Administrator, or facility appointed designee. Report allegations or suspected abuse, neglect, or exploitation immediately to: Administrator, Other Officials in accordance with State Law, State Survey and Certification agency through established procedures.</p> <p>-2. 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p> <p>-- .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish.</p> <p>--It includes verbal abuse .physical abuse, and mental abuse .</p> <p>--'Willful' means the individual deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>-3. 'Verbal Abuse' means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.</p> <p>- .5. 'Physical Abuse' includes, but not limited to hitting, slapping, punching and kicking. It also includes controlling behavior through corporal punishment.</p> <p>-6. 'Mental Abuse' includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation .</p> <p>- .8. 'Involuntary Seclusion' refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative .</p> <p>- .11. 'Mistreatment' means inappropriate treatment or exploitation of a resident.</p> <p>*The facility must:</p> <p>-1. Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>(continued on next page)</p>

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>- .5. Prevention of Abuse, Neglect, and Exploitation - The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents:</p> <p>-- .d. Provide education on what constitutes abuse, neglect and misappropriation of property.</p> <p>--e. React to all allegations or questions of abuse by residents, family members, employees or visitors.</p> <p>--f. Take appropriate actions when abuse, neglect or exploitation is suspected.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46453</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review, the provider failed to notify the required entities of an allegation of physical abuse by resident 3's spouse towards one of two sampled residents (1), and an allegation of verbal abuse and involuntary seclusion by resident 3's spouse towards one of two sampled residents (2). Findings include:</p> <p>1. Review of the SD DOH FRI submitted on 6/15/24 at 7:35 p.m. revealed:</p> <p>*Registered nurse (RN) D reported that certified nurse aide (CNA) C witnessed resident 3's spouse wheeling resident 1 down the hall.</p> <p>*Resident 1 was holding his hand up as if he may have been attempting to grab resident 3's spouse.</p> <p>*In response to resident 1's action, resident 3's spouse hit [resident 1] over the head with her right hand.</p> <p>*RN D immediately assessed resident 1 and when asked if resident 3's spouse hit him, his response was that resident 3's spouse tried to hit him, and I blocked her.</p> <p>*RN D's physical assessment did not reveal any redness, bruising, or raised areas on resident 1's head.</p> <p>*Resident 1 then stated that resident 3's spouse did hit him on his temple, but not very hard.</p> <p>*During interview with resident, he did not show any fear of the situation.</p> <p>*RN D notified facility administrator. Administrator will be in the facility to discuss the situation with [resident 3's spouse].</p> <p>*The report indicated that local law enforcement and the South Dakota Department of Human Services (DHS) were not notified.</p> <p>-Under the section Why or why not? for law enforcement notification, the report indicated, Administrator will be in facility in am [a.m.]</p> <p>-Under the section Why or why not? for DHS notification, the report indicated, Notified Ombudsman via email.</p> <p>2. Interview on 6/24/24 at 5:32 p.m. with administrator A regarding the FRI revealed:</p> <p>*She had contacted both her advisor and the regional ombudsman and asked if they should contact the police.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Both her advisor and the ombudsman had said to not contact the police because resident 1 did not want to press charges.</p> <p>*She confirmed that no one had contacted law enforcement or DHS about the incident.</p> <p>3. Interview on 6/24/24 at 6:15 p.m. with the SD DOH long term care nurse advisor about the above incident revealed she confirmed the provider was obligated to contact law enforcement.</p> <p>4. Interview on 6/24/24 at 6:39 p.m. with resident 3's spouse about the above incident revealed:</p> <p>*A verbal agreement was made between the administrator and resident 3's spouse to not speak with resident 1, and to not touch any resident except resident 3.</p> <p>*Resident 3's spouse declined any further interview with the survey team.</p> <p>*Two police officers arrived at that time to gather statements.</p> <p>5. Interview on 6/25/24 at 12:41 p.m. with dietary aide F about the above incident revealed:</p> <p>*She confirmed she was working on the evening of 6/15/24.</p> <p>*No one had interviewed her about the incident to obtain her formal account.</p> <p>*She had not seen the events on 6/15/24 unfold but had seen a similar situation between resident 1 and resident 3's wife before.</p> <p>-It happened within the previous week of 6/15/24. It may have happened on 6/13/24, but she could not remember.</p> <p>-Resident 2 was sitting in his normal spot in the dining room.</p> <p>-Resident 1 wheeled himself into the dining room.</p> <p>-They started bickering at each other.</p> <p>-She could not understand what they were arguing about.</p> <p>-Resident 3's spouse grabbed resident 1's wheelchair to take him out of the dining room.</p> <p>-She overheard resident 3's spouse call resident 1 incompetent and asshole.</p> <p>-Dietary aide F reported what she overheard to both the CNA and the nurse on duty at that time.</p> <p>-She could not remember the names of the CNA or the nurse.</p> <p>*Dietary aide F indicated that resident 3's spouse was known to fly off the handle with staff, and sometimes other residents.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Interview on 6/25/24 at 2:42 p.m. with the regional ombudsman revealed that calling the ombudsman did not fulfill the mandatory reporting requirements, as the ombudsman was not a mandatory reporter.</p> <p>7. Interview on 6/25/24 at 5:24 p.m. with administrator A regarding the above incident revealed:</p> <p>*She was not aware of dietary aide F's account as explained in finding 5.</p> <p>*She was not aware that the ombudsman was not part of the required reporting network.</p> <p>*She stated again that the ombudsman recommended to not contact the police as resident 1 did not want to press charges against resident 3's spouse.</p> <p>8. Review of the provider's investigation documentation revealed:</p> <p>*Administrator A, director of human resources I, and resident 3's spouse met at the facility on 6/16/24 at around 11:00 a.m.</p> <p>*Resident 3's spouse admitted to bringing resident 2 back to his room and told him he had to stay there 'until he could learn to be a grown man.'</p> <p>9. Review of resident 2's electronic medical record revealed there was no documentation to support the resident's wife or his primary care provider had been notified about the incident between resident 2 and resident 3's spouse as explained in finding 8.</p> <p>10. Review of the provider's February 2024 Abuse policy revealed:</p> <p>*Policy Explanation and Compliance Guidelines:</p> <p>*1. The Abuse coordinator in the facility is the Director of Nursing, Administrator, or facility appointed designee. Report allegations or suspected abuse, neglect, or exploitation immediately to: Administrator, Other Officials in accordance with State Law, State Survey and Certification agency through established procedures.</p> <p>* .9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should:</p> <p>- .d. Notify the attending physician, resident's family/legal representative and Medical Director</p> <p>- .f. Contact the State Agency and the local Ombudsman office to report the alleged abuse.</p> <p>-g. If a crime, or suspicion of a crime has occurred, notify the local law enforcement agency.</p> <p>*10. The facility must annually notify covered individuals' obligation to comply with the following reporting requirements:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-a. Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any responsible [reasonable] suspicion of a crime against any individual who is a resident of or is receiving care from the facility.</p> <p>-b. Each covered, individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.</p> <p>* .13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must:</p> <p>-a. Ensure that all alleged violations .are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve resident abuse or result in serious bodily injury .to the administrator of the facility and to other official (including the State Survey Agency and adult protected services where state law provides for jurisdiction in long-term care facilities) in accordance with State law.</p> <p>*The Administrator should follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final, as required by state agencies.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>46453</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), investigation review, interview, and policy review, the provider failed to thoroughly investigate an allegation of physical abuse and verbal abuse experienced by one of two sampled residents (1), and involuntary seclusion and verbal abuse experienced by one of two sampled residents (2). Findings include:</p> <p>1. Review of the SD DOH FRI submitted on 6/15/24 at 7:35 p.m. revealed:</p> <ul style="list-style-type: none"> *Registered nurse (RN) D reported that certified nurse aide (CNA) C witnessed resident 3's spouse wheeling resident 1 down the hall. *Resident 1 was holding his hand up as if he may have been attempting to grab resident 3's spouse. *In response to resident 1's action, resident 3's spouse hit [resident 1] over the head with her right hand. *RN D immediately assessed resident 1 and when asked if resident 3's spouse hit him, his response was that resident 3's spouse tried to hit him, and I blocked her. *RN D's physical assessment did not reveal any redness, bruising, or raised areas on resident 1's head. *Resident 1 then stated that resident 3's spouse did hit him on his temple, but not very hard. *During interview with resident, he did not show any fear of the situation. *RN D notified facility administrator. Administrator will be in the facility to discuss the situation with [resident 3's spouse]. <p>2. Review of the provider's investigation documentation regarding the above incident revealed:</p> <ul style="list-style-type: none"> *There was a handwritten statement from CNA C. *There was a typed summary of the conversation administrator A had with resident 3's spouse from the morning of 6/16/24. -The summary revealed that resident 3's spouse admitted to bringing resident 2 back to his room and told him he had to stay there 'until he could learn to be a grown man.' -There was no documentation to support that the provider investigated this allegation further. *There was no documentation to support that other staff had been interviewed about the incident. *There was no documentation to support that residents had been interviewed, other than residents 1 and 2. <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Interview on 6/24/24 at 5:32 p.m. with administrator A regarding the above incident revealed:</p> <ul style="list-style-type: none"> *The incident happened on Saturday 6/15/24 around 6:30 p.m. *She was informed of the incident on 6/15/24 and instructed RN D to complete a state report and obtain a written statement from CNA C. *Director of human resources (DHR) I and administrator A came to the facility on Sunday 6/16/24 and met with resident 3's spouse at around 11:00 a.m. to discuss the incident. -They made a verbal agreement with resident 3's spouse to not move or touch other residents. -During that conversation, resident 3's spouse admitted to moving resident 2 to his room and told him, You can come out when you can act like a grown man. -Resident 3's spouse did not admit to hitting resident 1. *Resident 1 was interviewed several times on the evening of 6/15/24. -He was not a good historian. -One time he said that resident 3's spouse hit him, and another time he said that I blocked it. -He was not consistent with answering if he was hurt or not. *Resident 3's spouse had a pattern when she visited. She came around 11:00 a.m., stayed through the lunch hour, left for a couple of hours in the afternoon, came back to the facility around 4:00 p.m., and stayed until resident 3 went to bed. -This pattern was an everyday occurrence. *Administrator A met with the manager's team on the morning of 6/17/24 to inform them of the situation. -She instructed the managers to make more of a presence throughout the facility during the times that resident 3's spouse was known to be in the building. -She confirmed there was no documentation to support the increased surveillance of resident 3's spouse. *Administrator A confirmed she had not informed staff of that specific incident or to keep a closer eye on resident 3's spouse. Rather, she explained that staff were reeducated on monitoring call lights more closely. -There was no documentation to support that. *The regional ombudsman was scheduled to present on resident rights at the provider's all-staff meeting on 6/25/24. <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER United Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 405 First Ave Brookings, SD 57006	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Interview on 6/24/24 at 6:25 p.m. with CNA E regarding the above incident revealed:</p> <ul style="list-style-type: none"> *He confirmed he was working on the evening of 6/15/24. *He did not witness the incident. *There was a meeting about the incident at the nurse's station including CNA E, CNA C, and RN D. *He was not interviewed as part of a formal investigation into that incident. *He had not been re-educated or briefed about the incident or to keep an eye out for family members or visitors interacting with a resident who was not their person. <p>5. Interview on 6/24/24 at 6:39 p.m. with resident 3's spouse about the above incident revealed:</p> <ul style="list-style-type: none"> *A verbal agreement was made between the administrator and resident 3's spouse to not speak with resident 1, and to not touch any resident except resident 3. *Resident 3's spouse declined any further interview with the survey team. <p>6. Interview on 6/25/24 at 10:20 a.m. with resident 1 regarding the above incident revealed he:</p> <ul style="list-style-type: none"> *Denied having any issues with other residents, staff, or visitors. *Was unable to remember the incident. *Confirmed he felt safe in the facility and had not concerns regarding his safety. <p>7. Interview on 6/25/24 at 10:51 a.m. with resident 4 regarding safety revealed he:</p> <ul style="list-style-type: none"> *Confirmed he felt safe in the facility. *Got along with the other residents. *Denied seeing any arguments between other residents and/or their visitors. <p>8. Interview on 6/25/24 at 11:00 a.m. with resident 5 regarding safety revealed she:</p> <ul style="list-style-type: none"> *Had no concerns about her safety. *Denied seeing any altercations with other residents, family, or visitors. <p>9. Interview on 6/25/24 at 11:09 a.m. with resident 6 regarding safety revealed he:</p> <ul style="list-style-type: none"> *Stuck to his room most of the time because people yell a lot. *Gave nondescript answers to questions. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-We talked about going to get a staff member if someone is bothering [them].</p> <p>*They have had conversations previously with resident 3's spouse about resident rights.</p> <p>-She did not have documentation to support all their conversations with resident 3's spouse about her behavior.</p> <p>*She confirmed there was no visitor sign-in sheet.</p> <p>*She confirmed there was no documentation to support her and the management team's increased presence throughout the building to monitor resident 3's spouse.</p> <p>13. Interview on 6/25/24 at 3:24 p.m. with CNA C regarding the above incident revealed:</p> <p>*After supper on the evening of 6/15/24, he was in the nurse's station to receive shift-to-shift report.</p> <p>*After report, he walked out into the hallway.</p> <p>-Resident 2's door was already closed, so he assumed resident 2 already went back to his room for the night.</p> <p>-He walked past the main hallway and witnessed resident 3's spouse wheeling resident 1 towards his room.</p> <p>-He saw resident 1 reaching upwards at resident 3's spouse with his right hand.</p> <p>-Resident 3's spouse whacked resident 1 across the head with their right hand.</p> <p>-He went directly to the nurse's station and reported what he saw to RN D and licensed practical nurse (LPN) L.</p> <p>-LPN K left after that because it was the end of her shift.</p> <p>*He confirmed that no one assessed resident 2. I didn't even think to check on him.</p> <p>*He confirmed no one asked resident 3's spouse to leave. They left at their usual time of 7:30 p.m.</p> <p>*He confirmed he gave a written statement to RN D, but no one else had interviewed him about the incident.</p> <p>14. Interview on 6/25/24 at 2:52 p.m. with resident 3 regarding safety revealed he:</p> <p>*Had no concerns with other residents or staff.</p> <p>*Verbalized no complaints.</p> <p>15. Interview on 6/25/24 at 4:06 p.m. with resident 2 regarding safety revealed he:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Confirmed that the staff treat him well and that he felt safe within the facility.</p> <p>*Could not remember any specific incident where a visitor said any unkind things to him.</p> <p>*Indicated there was one resident [resident 1] that annoyed him, but other than that he felt safe.</p> <p>16. Interview on 6/25/24 at 4:18 p.m. with LPN K regarding the above incident revealed:</p> <p>*She confirmed she was working on 6/15/24, but she was on a different unit at the time of the incident.</p> <p>*The incident happened after 6:00 p.m.</p> <p>*She went to the South Ridge unit to give report to RN D for the night.</p> <p>*CNA C came into the nurse's station and informed them of what happened.</p> <p>*She recalled another time about a year ago where resident 3's spouse snapped at another resident.</p> <p>-That resident had dementia and talked non-stop.</p> <p>-She could not recall any more details regarding that incident.</p> <p>*No one had formally interviewed her as part of an investigation regarding the 6/15/24 incident.</p> <p>*She voiced no concerns regarding resident safety when resident 3's spouse was present.</p> <p>17. Interview on 6/25/24 at 4:53 p.m. with director of social services G about the above incident revealed:</p> <p>*As part of the investigation into this incident, she interviewed only residents 1 and 2 regarding their feelings of safety.</p> <p>*No other residents were interviewed.</p> <p>18. Interview on 6/25/24 at 5:24 p.m. with administrator A regarding the incident revealed:</p> <p>*She confirmed she was not aware of the previous situation with resident 1 and resident 3's spouse when dietary aide F overheard the spouse calling resident 1 incompetent and asshole.</p> <p>Continued interview on 6/26/24 at 9:15 a.m. with administrator A revealed:</p> <p>*She confirmed she did not talk to other staff again as part of the investigation. The only staff interviews conducted were with RN D and CNA C.</p> <p>-I felt I didn't need to do that because [resident 3's spouse] admitted to everything.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*She confirmed they had a verbal agreement with resident 3's spouse to not touch other residents and to not speak with resident 1.</p> <p>-There was no written or signed agreement.</p> <p>*To further prevent something like that from happening again, she and the management team were making more of a presence on the floor when resident 3's spouse was there.</p> <p>-She confirmed again that they were making visual observations and not making any written accounts.</p> <p>Continued interview on 6/26/24 at 10:57 a.m. with administrator A revealed:</p> <p>*She confirmed the only residents interviewed as part of the investigation were residents 1 and 2.</p> <p>*Residents were asked about feelings of safety with their normal quarterly assessments.</p> <p>*When asked why they did not interview any other residents regarding feelings of safety or if anyone else had noticed strange interactions with visitors, she said, You guys already asked other residents and they said they feel safe.</p> <p>19. Review of the provider's February 2024 Abuse policy revealed:</p> <p>*Policy Statement: Each resident has the right to be free from abuse, neglect . This includes but is not limited to freedom from corporal punishment, involuntary seclusion . Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals.</p> <p>*Policy Explanation and Compliance Guidelines:</p> <p>-1. The Abuse coordinator in the facility is the Director of Nursing, Administrator, or facility appointed designee. Report allegations or suspected abuse, neglect, or exploitation immediately to: Administrator, Other Officials in accordance with State Law, State Survey and Certification agency through established procedures.</p> <p>*The facility must:</p> <p>- .5. Prevention of Abuse, Neglect, and Exploitation - The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents:</p> <p>-- .e. React to all allegations or questions of abuse by residents, family members, employees or visitors.</p> <p>--f. Take appropriate actions when abuse, neglect or exploitation is suspected.</p> <p>- .6. Identification of Abuse, Neglect, and Exploitation - The facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indicators:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--a. Resident, staff, or family report of abuse</p> <p>-- .e. Verbal abuse of a resident overheard.</p> <p>--f. Physical abuse of a resident observed.</p> <p>- .7. Investigation of Alleged Abuse, Neglect and Exploitation. - When suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted.</p> <p>--Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include:</p> <p>---a. Interview the involved resident, if possible, and document all responses. If a resident is cognitively impaired, interview the resident several times to compare responses.</p> <p>---b. If there is no discernible response from the resident, or if the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident.</p> <p>---c. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement.</p> <p>---d. Document the entire investigation chronologically.</p> <p>- .9. Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should:</p> <p>-- .c. Initiate an investigation immediately.</p> <p>-- .e. Obtain witness statements, following appropriate policies. Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately.</p> <p>-- .i. Document actions taken in steps above in the medical record.</p> <p>- .13. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must:</p> <p>-- .b. Have evidence that all alleged violations are thoroughly investigated.</p> <p>-- .d. Report the results of all investigation to the administrator or his or her designated representative and to the other official in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*The policy did not indicate what actions should have been taken if the alleged abuse involved a family member or visitor.</p>		