STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Living Community	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on the South Dakota Department of Health (SD DOH) complaint intake review, record review, interview, and policy review, the provider failed to adequately monitor for neurological changes and follow the provider's falls protocol for two of three sampled residents (1 and 2) after they had fallen.Findings include:1. Review of the SD DOH complaint intake received on 4/7/25 revealed:*An anonymous community member called to express their concerns about resident falls at the facility.*Resident 1's falls, which had resulted in issues, was specifically mentioned with no explanation of what those issues were. 2. Review of resident 1's electronic medical record (EMR) revealed:*Her 6/10/25 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated she had severe cognitive impairment.*Her diagnoses included Parkinson's Disease, dementia, anxiety, muscle weakness, repeated falls, hypertension, chronic pain, and wandering. -Parkinson's Disease affects brain cells, causing movement and balance problems.-Dementia causes memory loss and confusion, affecting daily life activities.-Anxiety makes a person feel worried or scared about things often.-Muscle weakness means a person's muscles are too weak to work well.-Repeated falls means falling often without a clear reason.-Hypertension is high blood pressure.-Chronic pain means the person experiences long-lasting pain that does not go away easily.-Wandering is when a person becomes lost or moves around without purpose.*Her care plan interventions included:-She needed the assistance of one staff member for transfers and supervision/touching assistance with her walker, staff assisted her as needed, and used a wheelchair as needed.-She refused to use her walker at times.*She fell, unwitnessed, on 1/25/25.-Her neurological evaluation (an assessment of nerve function, reflexes, coordination, motor skills, sensation, reflexes, and mental status) (neuro eval) was not fully completed.--Staff failed to assess her level of consciousness (LOC), pupil response, motor functions, pain, and temperature at 5:30 p.m. Staff also did not assess her LOC, pupil response, motor function, and pain response at 6:30 p.m. *She fell, unwitnessed, on 1/28/25.-Her neuro eval was not fully completed.--Staff failed to assess her pupil response, motor function, pain response, and vital signs at 5:55 p.m. A note stated, getting ready for bed/BR [bathroom]. Between 6:10 p.m. and 8:25 p.m. her LOC, pupil response, motor functions, and pain response was not completed. At 9:25 p.m. and 10:25 p.m. her LOC, pupil response, motor functions, and pain response were not completed, and the nurse did not initial the assessments.-Her blood sugar was not measured as part of the falls protocol (assessment and follow-up processes after a resident falls).*She fell, unwitnessed, on 2/1/25.-Her neuro eval was not fully completed.--At 11:15 a.m. staff did not assess the pupil response, motor functions, pain response, or vital signs. A note stated, eating lunch-no issues noted.-Her blood sugar was not measured as part of the falls protocol.*She fell, unwitnessed, 2/17/25 and sustained a bump to the side of her head.-Her neuro evaluation was not fully completed.--The staff failed to assess the pupil response and obtain vital signs between 2:00 p.m. and 3:45 p.m. Staff did not assess her LOC, pupil response, motor functions, pain response, or vital signs at 7:00 p.m.-Her blood sugar was not measured as part of the falls protocol.*She fell, witnessed, on 3/18/25.-Her blood sugar was not measured as part of the falls protocol.*She fell, unwitnessed, on 4/1/25.-Her neuro evaluation was not fully completed.--The staff did not initial the completed assessments between 7:30 p.m. and 8:00 p.m. On 4/2/25 at 1:00 a.m., her LOC, pupil response, motor functions, and pain response were not assessed. At 2:00 a.m., her LOC, pupil response, motor functions, pain, and vital signs were not assessed. At 6:00 a.m. her LOC, pupil response, motor functions, and pain response were not assessed.-Her blood sugar was not measured as part of the falls protocol.*She fell, unwitnessed, on 5/25/25.-Her evaluation was not fully completed.--Staff failed to assess her LOC, pupil response, motor functions, and pain response from 6:50 p.m. to 9:20 p.m., and from 10:20 p.m. to 5:20 a.m. on 5/26/25.-Her blood sugar was not measured as part of the falls protocol.*She fell, witnessed, in her bathroom on 6/22/25.-Her blood sugar was not measured as part of the falls protocol.*She fell, unwitnessed, on 7/6/25 in her bathroom.-Her neurological evaluation was not fully completed.--Staff failed to initial the completed assessments at 9:05 a.m., 9:20 a.m., 12:50 p.m., 1:50 p.m., and 3:50 p.m. Staff failed to assess pain, vital signs, and initial the assessment at 11:20 a.m.-Her blood sugar was not measured as part of the falls protocol. 3. Review of resident 2's EMR revealed:*Her 6/18/25 BIMS assessment score was 3, which indicated she had severe cognitive impairment.*Her diagnoses included unspecified dementia, dysuria, chronic kidney disease stage 3, and type 2 diabetes mellitus.-Dysuria means pain with urination. -Chronic kidney disease stage 3 means a person's kidneys are working at half the capacity.-Type 2 diabetes mellitus means a person's blood sugar cannot be controlled well by insulin.*She fell, unwitnessed, on 2/8/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on the South Dakota Department of Health (SD DOH) complaint intake review, interview, observation, record review, and policy review, the provider failed to communicate with staff and implement fall prevention interventions, which potentially contributed to at least six falls (four of which resulted in injuries) from 2/1/25 to 7/6/25 for one of two sampled residents (1).Findings include: 1. Review of the SD DOH complaint intake received on 4/7/25 revealed:*An anonymous community member called to express their concerns about resident falls at the facility.*They specifically mentioned resident 1's falls which had resulted in issues.-They did not explain what those issues were. 2. Review of resident 1's electronic medical record (EMR) revealed:*Her 6/10/25 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated had severe cognitive impairment.*Her diagnoses included Parkinson's disease, dementia, anxiety, muscle weakness, repeated falls, hypertension, chronic pain, and wandering.-Parkinson's disease affects brain cells, causing movement and balance problems.-Dementia causes memory loss and confusion, affecting daily life activities.-Anxiety makes a person feel worried or scared about things often.-Muscle weakness means a person's muscles are too weak to work well.-Repeated falls means falling often without a clear reason. -Hypertension is high blood pressure.-Chronic pain means the person experiences long-lasting pain that does not go away easily.-Wandering is when a person becomes lost or moves around without purpose.*She fell on 2/1/25 in the dining room when staff had briefly left her alone.*She fell on 2/8/25 in the dining room and sustained a tiny skin tear on her left hand.*She fell on 2/17/25 in the dining room and sustained a bump to the side of her head.*She had fallen on 4/1/25 at around 7:13 p.m. in the hallway and was found lying face down and sustained a laceration (cut or torn skin) on her cheek.-She went to the emergency room for evaluation.-Per the 4/1/25 fall report, staff were to assist her with using the toilet her every two hours. The last time she was assisted to the bathroom was at 4:30 p.m., which was 2 hours and 43 minutes before fall. Staff were to also monitor her closely when she was out of her room.*She fell in her bathroom on 6/22/25 after a CNA left her alone to grab supplies. As the CNA was re-entering the bathroom, resident 1 attempted to stand up and fell.*She fell on 7/6/25 in her bathroom after a CNA left her alone to grab supplies.-Per her care plan, she was not supposed to be left alone.-She sustained a bump to the back of her head and a skin tear to her right elbow that required Steri-Strips [adhesive strips used to close a wound]. 3. Interview on 7/9/25 at 10:13 a.m. with certified nursing assistance (CNA) N revealed:*Resident 1 had fallen before, but she could not remember if she had fallen recently.*A few months prior, resident 1 had fallen and received a bruise to her face.*The care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) binder was not up to date, as it contained care plans for residents who had since passed away or moved to other halls.*Sometimes there were pocket care plans (a document that identifies residents' care needs and interventions) inside the resident's closet or cabinet in their rooms.*She indicated the lead CNAs would help with updating the resident pocket care plans. 4. Observation on 7/9/25 at 10:42 a.m. of resident 1's room revealed:*There was a sign on the outside of the bathroom door and above the toilet that stated, Please do not leave me unattended while I am using the bathroom.*There was no pocket care plan inside her closet or cabinet doors. 5. Interview on 7/9/25 at 3:00 p.m. with CNA I revealed:*Resident 1 had a diagnosis of Parkinson's disease.*A therapy wedge pillow block was placed by resident 1's right side when she was lying in bed to help her identify where the edge of the bed was. The wedge also helped her legs from flailing around due to her Parkinson's disease.*She stated that resident 1 was the biggest fall risk in the building.*Resident 1 was in a wheelchair for a while after she had fallen, as she was scared of falling. CNA I indicated that resident 1 was also scared to sit on the toilet.*Staff were supposed to always keep resident 1 within their eyesight and were to chart about her whereabouts every two hours in the EMR.-Resident 1 required 24/7 [24 hours a day, 7 days a week] supervision.*Resident 1 was not allowed to be in the bathroom by herself, and that staff were to remain in the bathroom with her. 6. Interview on 7/9/25 at 3:15 p.m. with unlicensed assistive personnel (UAP) G revealed:*Resident 1 was impulsive, would stand up from her chair quickly, and often tripped over her shoes.*Resident 1 was not included in the pocket care plan binder, but she was included on the family sheet located in a different binder.-The family sheets included a list of residents on that unit and their special care needs, such as their diet order, code status, what size of incontinence products to use, and how the resident transferred. 7. Review of the undated SUNSHINE [the secured memory care unit] FAMILY 1 sheet regarding resident 1 revealed:*She needed one staff member to assist her with transfers and required the use of a walker.* Special equipment included a VST (a

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the provider failed to implement and effectively manage a nursing restorative therapy program for one of one sampled resident (1).Findings include: 1. Review of the SD DOH complaint intake received on 4/7/25 revealed:*An anonymous community member called to express their concerns about resident falls at the facility.*They specifically mentioned resident 1's falls, which had resulted in issues.-They did not explain what those issues were. 2. Review of resident 1's care plan revealed:*A focus area that read, I am in need of restorative therapy to maintain my functions and abilities. Created on 6/25/24. *Interventions that included restorative programming included:- NURSING REHAB/RESTORATIVE: Transfer Program #1 : Nu-step at level 5 for up to 15 minutes up to [6 to 7] days a week. Created on 6/25/24.- NURSING REHAB/RESTORATIVE: Transfer Program #1 : Nu-step at level 5 for upto 15 minutes up to [6 to 7] days a week. Goal to maintain ability [and] strength to remain free of fall with a major injury. Created on 2/25/24. Revised on 2/25/24.- NURSING REHAB/RESTORATIVE: PASSIVE ROM [range of motion] Program #1 Static stretchingwith 30 second holds to upper and lower extremities for 15 minutes up to [6 to 7] days aweek. Goal to prevent contractures [and] remain comfortable. Created on 2/25/24. Revised on 2/25/24. - Restorative program for balance and lower extremity strengthening. Created on 12/4/24. 3. Review of resident 1's electronic medical record (EMR) revealed:*One of the items on the tasks page for certified nursing assistants (CNAs) to chart on included Restorative Nursing-RESTORATIVE: Transfer Program #1 : Nu-step at level 5 for up to 15 minutes up to [6 to 7] days a week.-In the 30-day lookback report, the response was charted as Not Applicable on 7/6/25, Resident Not Available on 7/7/25, and 0 in the Amount column on 7/9/25.*Her diagnoses included chronic pain, low back pain, neurocognitive disorder with Lewy bodies, muscle weakness, unsteadiness on feet, anxiety disorder, dementia, and Parkinson's disease with dyskinesia (involuntary, uncontrolled muscle movements often caused by neurological disorders).-Chronic pain means the person experiences long-lasting pain that does not go away easily.-Neurocognitive disorder with Lewy bodies is a brain disorder causing memory loss, hallucinations, and movement problems.-Muscle weakness means a person's muscles are too weak to work well.-Unsteadiness on feet means trouble standing or walking without losing balance.-Anxiety disorder makes a person feel worried or scared about things often.-Dementia causes memory loss and confusion, affecting daily life activities. 4. Interview on 7/10/25 at 9:00 a.m. with CNA J revealed:*There were two restorative CNAs in the therapy department.*She believed that resident 1 was the only resident on the memory care unit that had a restorative program. -Resident 1 had not participated in the restorative therapy program for several months.*She explained that resident 1 had a fall with injury, and the restorative program would probably restart after she was more stabilized.-She did not explain when resident 1 had that fall, or what type of injury the resident sustained. 5. Interview on 7/10/25 at 9:59 a.m. with physical therapy assistant (PTA) H revealed:*She confirmed that resident 1 was not currently receiving skilled therapies.*The last time resident 1 was discharged from skilled therapies was on 6/19/24. 6. Interview on 7/10/25 at 11:37 a.m. with CNA L revealed:*She was one of the restorative CNAs and had been working at the facility for nine years.-She had been the only restorative CNA for the past three to four years.*A second restorative CNA was recently hired, and she helped train them on restorative programming.*She confirmed resident 1 had a restorative program in place.-Resident 1 would refuse to participate in the programming.*She confirmed she was supposed to chart that the resident had refused, but she had not been doing that.*She explained, when I was by myself, I focused on the other people who would be more willing to do the program.*It had been several months since resident 1 last participated in the restorative program.*She would often get pulled from the restorative therapy program as she was reassigned to fill in for other CNAs that called out.*There were about 25 residents with a custom restorative therapy program.-She could not handle that caseload by herself, which is why a second restorative aide was hired.*She confirmed that director of nursing (DON) B oversaw the restorative therapy program.*The restorative program got pushed to the side because she was getting pulled to work the nursing floor often. 7. Interview on 7/10/25 at 12:53 p.m. with case managers C and D revealed:*They denied that the restorative program was pushed to the side, explaining that it was hard to keep up with because they had one restorative aide conducting the program. They hired a second restorative aide to help with the caseload. *They confirmed that DON B managed the restorative therapy program.*They expected the restorative aides to chart each time a resident refused or participated in the restorative program. 8. Interview on 7/10/25 at 2:05 p.m. with DON B revealed:*She confirmed that resident 1 was supposed to have a restorative therapy