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	08/14/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, and record review, the provider failed to protect one of one sampled resident's (1) right to be free from potential neglect by two of three certified nursing assistants (CNAs) (E and J) who had neglected to assist resident 1 off the toilet in a reasonable amount of time, and did not inform the oncoming shift that the resident was still on the toilet, which resulted in the resident sitting on the toilet for at least two hours. Findings include: 1. Review of the provider's 7/28/25 submitted SD DOH FRI revealed that on 7/27/25 at around 1:30 p.m., CNA I had helped resident 1 onto the toilet using a stand-aid (a mechanical lift used to assist from a seated to a standing position) and then left to assist another resident. CNA I told CNAs E and J that resident 1 was on the toilet before he left the unit.Around 3:40 p.m., CNA C found resident 1 sleeping on the toilet and helped her off the toilet. Registered nurse (RN) H checked resident 1's skin, found some redness, and applied zinc ointment. The next day, DON B checked the resident's skin again and found no redness or bruising.CNAs E and J did not report that resident 1 was on the toilet during their shift change around 2:30 p.m. and did not check if the resident needed help. Both CNAs received disciplinary action and retraining.Resident 1 did not get hurt and showed no signs of pain. Resident 1's care plan was updated to include that staff were to check on her every five minutes while she was on the toilet. The critical event checklist and witness descriptions were completed, and resident 1's family was notified. Staff were re-educated on rounds and care plans. 2. Interview on 8/14/25 at 9:08 a.m. with CNA F revealed she was working on 7/27/25 when resident 1 was left on the toilet. She said that as part of the provider's investigation process, she was interviewed by the social worker about what happened that day and she confirmed her statement.She said that the provider changed how the CNAs were to perform their shift-to-shift report. Instead of completing report in the nurse's station, they were to walk with the oncoming shift to lay eyes on each resident to know their whereabouts and then give their report in the nurse's station. They had been doing that new process for a couple of weeks, and she thought it had been working well. 3. Interview on 8/14/25 at 10:52 a.m. with licensed practical nurse (LPN) G revealed that she was not present at the facility when resident 1 was left on the toilet, but she received a report about the event the next time she was scheduled to work. She explained the new expectation was for the direct care staff to complete walking rounds with the previous shift to lay eyes on each resident to know their whereabouts. 4. Interview on 8/14/25 at 11:03 a.m. with CNA D revealed that she was one of the CNAs who found resident 1 on the toilet at around 3:30 p.m. on 7/27/25. She explained that CNA C found resident 1 asleep on the toilet. CNA C asked CNA D for help to assist resident 1 off the toilet. Resident 1 did not show any signs or symptoms of distress or injury.She confirmed that during that shift-to-shift exchange, neither CNA E nor J had informed the oncoming CNAs (C and D) that resident 1 was on the toilet. They informed RN H about the incident, and she assessed the resident who found that the resident's bottom was reddened and applied some ointment. Since that incident, the nursing staff were expected to complete walking rounds during the shift-to-shift exchange to know where each resident was at. 5. The survey team attempted to contact CNA E for an interview by phone on 8/14/25 at 11:27 a.m. and left a voicemail. CNA E did not contact the survey team by the end of the survey on 8/14/25 at 4:35 p.m. 6. Phone interview on 8/14/25 at 11:29 a.m. with CNA J revealed that on 7/27/25, she and CNA E were assigned to resident 1's unit. CNA I was the float CNA (had shared assigned areas) for resident 1's unit and another unit. CNA I had taken resident 1 to the bathroom roughly after lunch. CNA I informed CNA J and CNA E about it, then left the unit. CNA J said, I didn't really think anything of it, as she thought that CNA E was assigned to resident 1. CNA J stated, I wasn't really doing her [resident 1's] cares that day, and explained that CNA E had been taking care of resident 1 that day. CNA J indicated that she assumed CNA E and CNA I had helped resident 1 off the toilet.After the incident, the management team investigated the incident and interviewed her. She confirmed that she signed a disciplinary action form.Since the incident, the nursing staff were expected to perform walking rounds with the previous shift to visualize each resident. The nurse managers had also been assigning each CNA residents to be primarily responsible for on the family sheets. The family sheets included groups of residents that included pertinent information to care for each resident, such as their diet order, and adaptive equipment they might require, how the resident transfers from surface to surface, and their code status. There were usually two CNAs per unit, and each CNA was assigned to care for half of the residents in their assigned unit. 7. The survey team attempted to contact CNA I for an interview by phone on 8/14/25 at 11:38 a.m. and