

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Aurora Brule Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 408 South Johnston Street White Lake, SD 57383	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to thoroughly investigate an allegation of abuse involving one of one certified nursing assistant (CNA) (V) who threw an incontinence brief at one of one sampled resident (8), told him to do it yourself, and left him on the toilet without providing care. The provider's failure to conduct a thorough investigation placed the other residents at risk for abuse and neglect by not determining if similar incidents had occurred, or if additional residents were affected. The facility's census at the time of survey was 44. Findings include: 1. Review of the provider's 2/24/26 SD DOH FRI revealed that resident 8 reported to licensed practical nurse (LPN) U that a staff member was rude to him that evening. Resident 8 told LPN U that when he needed assistance in the bathroom, the staff member told him to do it himself, gave resident 8 a brief, then left the room. Resident 8 was blind and was unable to provide the staff member's name. The provider interviewed all staff members who were scheduled to work at the facility that night and determined that CNA V was the staff member who provided care to resident 8 on the evening of 2/24/26. CNA V did not provide the resident's care according to the resident's care plan and substantiated the allegation of abuse. CNA V's employment with the facility was terminated on 2/26/26. 2. Interview on 7/29/26 at 10:37 a.m. with social services designee (SSD) D revealed that she interviewed resident 8 after the alleged abuse by CNA V. SSD D remembered speaking with resident 8 but was unable to interview CNA V as her employment was terminated. She stated that she did not interview other residents who were assigned to be cared for by CNA V to determine if any residents may have been abused by CNA V. She explained that she did not interview any other residents because nobody else came to me. 3. Review of the provider's Investigative Protocol Form revealed that an investigation into the incident was initiated on 2/25/26. The protocol form included eight interventions to be completed for the investigation. Those interventions were: description of the issue, immediate action taken, root cause analysis, policy review, in-service education form, focus audit form, investigative summary, and care plan review. The intervention areas for root cause analysis, in service education form, and focus audit form were not completed on the investigative protocol form for the 2/24/26 incident. 4. Interview on 7/29/26 at 11:29 a.m. with director of nursing (DON) B and administrator A revealed that administrator A and SSD D usually investigated allegations of abuse. Resident 8's roommate was interviewed by administrator A after the report of abuse from resident 8's abuse by CNA V and resident 8's roommate did not hear the incident in the bathroom on 2/24/26 because he had headphones on. They confirmed that the root cause analysis, in-service education form, and focus audits were not completed on the investigative protocol form of the 2/24/26 incident. They stated that no other residents under CNA V's care were interviewed to determine the extent of abuse, and that another incident could have occurred between CNA V and another resident while she worked at the facility. 5. Further interview on 7/29/26 at 12:12 p.m. with administrator A revealed that staff (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	education was provided at the all-staff meeting in March 2026 regarding abuse and neglect, but she could not provide a copy of that educational material. The staff education sign-in acknowledgement sheet included signatures of the staff members who attended that meeting, but not all signatures were legible to determine that all staff received the education on abuse and neglect. 6. Review of the provider's 1/14/26 Freedom from Abuse, Neglect, and Exploitation Policy revealed that the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, to ensure all identified incidents of alleged or suspected abuse/neglect are promptly investigated, and to ensure a complete review of existing incidents is documented. Investigation of abuse may include interviewing staff, residents, or other witnesses to the incident.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure that required physician visits (every 30 days for the first 90 days after the resident's admission and every 60 days thereafter) were alternated between personal visits by the physician and by the physician assistant (PA) after the physician makes the initial comprehensive visit for residents under a SNF stay (skilled nursing care covered by Medicare part A) for four of four sampled residents (4, 8, 29, and 43) who had SNF stays at the facility in the period reviewed from 7/4/25 through 7/29/26. Findings include: 1. Review of resident 8's electronic medical record (EMR) revealed that he admitted to the facility on [DATE]. He had a SNF stay that began on 10/9/25 and ended on 10/30/25. PA C assessed resident 8 on 7/22/25, 8/12/25, 10/14/25, 11/26/25, 12/10/25, 2/4/26, 4/8/26, 5/27/26, and 7/22/26. There was no documentation in his EMR that indicated he had a medical visit completed by a physician within the last year. 2. Review of resident 29's EMR revealed he admitted to the facility on [DATE]. He was assessed by PA C on 11/19/25 for his initial certification visit, 12/17/25 for his second certification visit, and 1/7/26 for his final 90-day certification visit. There was no documentation in his EMR that indicated he had a medical visit completed by a physician since he admitted . 3. Review of resident 4's EMR revealed she admitted to the facility on [DATE]. She had a SNF stay that began on 3/16/26 and ended on 4/24/26 and another SNF stay that began on 5/10/26 and ended on 5/19/26. PA C assessed resident 4 on 7/8/25, 9/2/25, 10/1/25, 10/28/25, 12/23/25, 1/28/26, 4/8/26, 6/3/26, and 7/8/26. She was assessed by a physician on 2/11/26 for a hospital follow-up and on 6/30/26 for an acute issue. 4. Review of resident 43's EMR revealed she admitted to the facility on [DATE]. She had a SNF stay that began on 3/23/26 and ended on 5/25/26. She was assessed by PA C on 3/25/26 for her initial certification visit, 4/22/26 for her second certification visit, and 5/20/26 for her 90-day certification visit. There was no documentation that indicated she had a physician visit or an examination completed by a physician since she admitted . 5. Interview on 7/28/26 at 11:21 a.m. with administrator A revealed that she thought that a non-physician practitioner (NPP), such as a PA, was allowed to see all of the residents for their standard medical visits. She was not aware that a physician was to conduct the resident's initial visit and every other 30-day physician visit after that for residents under SNF stays. 6. Interview on 7/29/26 at 11:15 a.m. with PA C revealed that she completed the residents' first provider visit after they admitted to the facility. She stated that a physician came to the clinic in town at least once a month, but she (PA C) usually saw the residents in the nursing home for their medical care and visits. She stated that there was always a physician on call and available to fill in for her if she was unavailable. 7. Review of the provider's undated Resident Policy Manual revealed that residents were required to have an examination by their physician prior to admission or within 48 hours after admission. After (continued on next page)		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission, residents would need to see their physician every 30 days for the first 90 days. 8. Review of the provider's April 2026 Policy and Procedure for Physician Rounds revealed that each resident would receive timely medical supervision by an attending physician, physician assistant, or nurse practitioner in compliance with federal and state laws.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and policy review, the provider failed to protect the residents' right to confidential personal medical information for two of two sampled residents (41 and 40) by one of one observed certified nurse aide (CNA) (S) who left residents' electronic medical records (EMR) information displayed on a computer screen mounted to the wall in the East hallway. Findings include: 1. Observation on 7/27/26 at 3:40 p.m. in the East hallway revealed CNA S was in the hallway entering data on a computer. She left the computer with resident 41's EMR information displayed on that computer screen and entered another resident's room. CNA S came out of that room and returned to the computer screen. She left the computer and answered another resident's call light at 3:42 p.m. with resident 40's EMR information displayed on the computer screen. CNA S came back out into the hallway and continued to use that same computer. At 3:46 p.m. CNA S left the computer to answer another resident's call light. The computer was left on a screen that displayed all the residents' names. At 3:50 p.m. CNA I walked down the hallway, paused and locked the computer screen, then continued down the hallway. 2. Interview on 7/27/26 at 3:55 p.m. with registered nurse (RN) Q revealed that the computer screens in the hallways were for staff members to use for charting the residents' care in the EMR system. She stated that when staff members were done using the computer, they were expected to lock the screen to protect the residents' private medical information. 3. Interview on 7/29/26 at 11:29 a.m. with director of nursing (DON) B and administrator A revealed that staff were expected to keep residents' medical information private by locking the computer screens when they were done charting in the EMR system. They agreed that any visitor or other resident could potentially use the computer's touch screen and access residents' medical information if the staff did not lock the screen. 4. Review of the provider's undated resident admission packet revealed a booklet called Nursing Home Residents' Rights. The booklet stated that residents have the right to approve or refuse anyone outside of the nursing home access to their personal and care records.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to protect the residents' right to be free from verbal and physical abuse for one of one sampled resident (8) who reported that he had an incontinence (involuntary urine or bowel leakage) absorbent brief thrown at him, was told to do it himself, and was left on the toilet without assistance by one of one certified nursing assistant (CNA) (V). Findings include: 1. Review of the provider's 2/24/26 SD DOH FRI revealed that resident 8 reported to licensed practical nurse (LPN) U that a staff member was rude to him that evening. Resident 8 told LPN U that when he needed assistance in the bathroom, the staff member told him to do it himself, gave resident 8 a brief, then left the room. Resident 8 was blind and was unable to provide the staff member's name. The provider interviewed all staff members who were scheduled to work at the facility that night and determined that CNA V was the staff member who provided care to resident 8 on the evening of 2/24/26. CNA V did not provide the resident's care according to the resident's care plan and substantiated the allegation of abuse. CNA V's employment with the facility was terminated on 2/26/26. 2. Review of resident 8's electronic medical record (EMR) revealed that he admitted to the facility on [DATE]. He had a 6/24/26 Brief Interview for Mental Status (BIMS) assessment score of 15 which indicated that his cognition was intact. He had diagnoses of reduced mobility, blindness, and lumber fusion (the surgical joining of two or more bones in the lower spine). Resident 8's 8/11/21 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated [resident 8] is completely blind, unable to see shapes, shadows with the intervention for the staff to assist the resident as needed with his activities of daily living (ADLs). Resident 8 had another 4/6/26 focus area that indicated [resident 8] has an ADL self-care performance deficit with the intervention for the staff to provide partial to moderate assistance with personal hygiene. 3. Interview on 7/27/26 at 10:58 a.m. with resident 8 revealed that he needed the staff's assistance with putting on a new incontinence brief due to his blindness, and difficulty bending over due to his history of back surgery. He remembered that a staff member threw a brief at him while he was on the toilet, and when he asked her for assistance with putting it on, she told him to do it yourself, and then left his room. Resident 8 pulled his call light cord, and another staff member helped him put the new brief on and get off the toilet. Resident 8 was not sure of the staff member's name who threw the incontinence brief at him. Resident 8 stated that incident was his only negative interaction with a staff member at the facility. He stated that CNA V did not introduce herself when she came into the room and he did not remember hearing her voice taking care of him after this incident. 4. Interview on 7/29/26 at 10:37 a.m. with social services designee (SSD) D revealed that she interviewed resident 8 after the alleged abuse by CNA V. SSD D remembered speaking with resident 8 but was unable to interview CNA V as her employment was terminated. She stated that she did not interview other residents who were assigned to be cared for by CNA V to determine if any residents may have been abused by CNA V. She explained that she did not interview any other residents because nobody else came to me. 5. Review of the provider's Investigative Protocol Form revealed that an investigation into the incident was initiated on 2/25/26. The protocol form included eight interventions to be completed for the investigation. Those interventions were: description of the issue, immediate action taken, root cause analysis, policy review, in-service education form, focus audit form, investigative summary, and care plan review. The intervention areas for root cause (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	analysis, in service education form, and focus audit form were blank on the investigative protocol form. 6. Interview and review of the Investigative Protocol Form on 7/29/26 at 11:29 a.m. with director of nursing (DON) B and administrator A confirmed that the root cause analysis, in-service education form, and focus audits were not completed in the investigative protocol form for the 2/24/26 incident. 7. Further interview on 7/29/26 at 12:12 p.m. with administrator A revealed that no audits of CNA V's interactions with residents or other staff interactions with residents were completed. Administrator A stated that staff education was provided at the all-staff meeting in March 2026 regarding abuse and neglect, but she could not provide a copy of that educational material. The staff education sign-in acknowledgement sheet included signatures of the staff members who attended that meeting, but not all signatures were legible to determine that all staff received the education on abuse and neglect. 8. Review of the provider's 1/14/26 Freedom from Abuse, Neglect, and Exploitation Policy revealed that the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, to ensure all identified incidents of alleged or suspected abuse/neglect are promptly investigated, and to ensure a complete review of existing incidents is documented. Investigation of abuse may include interviewing staff, residents, or other witnesses to the incident.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure an environment free of accident hazards for two of two sampled residents (29 and 43) who used electronic lift chairs in their rooms and were not assessed to determine the residents' ability to safely use those chairs independently, to mitigate the risk of accidents. Findings include: 1. Observation and interview on 7/26/2026 at 2:50 p.m. with resident 29 in his room revealed he was seated in an electronic lift chair with his feet elevated on the footrest, and the remote for the chair was draped over the armrest, within his reach. When the resident was asked if he knew how to use the remote to raise or lower his feet, he stated he did not know what the chair remote was for or how to use it. 2. Review of resident 29's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. He had diagnoses of Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia (a group of symptoms affecting memory, thinking, and social abilities), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Resident 29 fell at home and fractured his right arm and hip before he admitted to the facility in December 2025, and sustained a left hip fracture that was surgically replaced on 12/31/25. Resident 29's EMR did not include any documented assessment of his functional status, cognitive ability, strength, balance, judgment, or safety awareness related to his ability to independently use the electronic lift chair. No documentation indicated that he was evaluated for supervision needs, assistance needs, or environmental safety measures associated with his use of that chair. Resident 29's 5/20/26 Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated his cognition was severely impaired. His current undated care plan indicated his cognition was severely impaired. His current undated care plan indicated that he was to transfer with substantial/maximum assistance from staff, and he was at risk for falls due to his impaired cognition and mobility. His care plan intervention initiated on 2/23/26 indicated that the staff were to encourage him not to elevate his footrest while he was in the electronic lift chair, and that the staff were educated about that intervention. 3. Observation and interview on 7/26/2026 at 1:10 p.m. with resident 43 in her room revealed she was seated in an electronic lift chair with her feet elevated on the footrest, and the remote for the chair was draped over the chair's armrest, within her reach. Resident 43 denied knowing how to use the chair's remote or what the remote was for. 4. Observation on 7/27/2026 at 11:44 a.m. and on 7/28/26 at 1:50 p.m. revealed resident 43 was seated in her electronic lift chair with her feet elevated on the footrest, with the chair's remote draped over the armrest, within reach of the resident. 5. Observation and interview on 7/27/2026 at 5:10 p.m. with certified nursing aide (CNA) N and resident 43 in her room revealed CNA N asked resident 43 in her room revealed CNA N asked resident 43 if she could use her chair remote to lower her feet in the electronic lift chair, and if she knew what the remote was for. Resident 43 stated, It's for a whole lot of nothing. The CNA stated that staff knew which residents could have their feet raised on the footrest while sitting in the electronic recliner. 6. Review of resident 43's EMR revealed she admitted to the facility on [DATE]. She had diagnoses of anxiety and rheumatoid arthritis (inflammation of the joints). Resident 43 fell and fractured her right hip on 3/17/26 before she admitted to the facility. Resident 43's EMR did not include any documented assessment of her functional status, cognitive ability, strength, balance, judgment, or safety awareness related to her ability to independently use the electronic lift chair. No (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation indicated that she was evaluated for supervision needs, assistance needs, or environmental safety measures associated with her use of that chair. Her 6/24/26 BIMS assessment score was 4, which indicated her cognition was severely impaired. Her current undated care plan indicated that she had an activities of daily living (ADL) self-care performance deficit related to her impaired balance, limited mobility, and musculoskeletal impairment due to her right hip fracture. Her 3/25/26 initiated care plan intervention indicated she required partial to moderate assistance from staff to stand and pivot to her wheelchair and needed to use a sit-to-stand mechanical lift (a medical safety device used to safely move people who cannot stand or walk on their own) for toileting. 7. Interview on 7/26/2026 at 3:02 p.m. with contracted travel CNA T revealed she utilized the resident's care plans in Point Click Care (PCC) (an electronic medical records system) to determine how to care for the residents. She indicated that she was trained on how to care for each resident by the facility staff upon hire. 8. Interview on 7/28/26 at 3:25 p.m. with administrator A revealed the staff did not assess residents for safety concerns when using a recliner, whether manual or electric. 9. Interview on 07/29/2026 1:15 PM with director of nursing (DON) B revealed staff were aware of which residents could use the electronic lift chair remote and if their feet should be elevated when they were sitting in those chairs. She indicated that the chair's remote should be left in the chair's side pocket if the resident did not know how to use it. 10. Review of the provider's reviewed 2/24/26 Resident Accident Prevention policy and procedures revealed It is the policy of Aurora [NAME] Care and Rehab to ensure that the resident's environment remains as free as possible of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents. An accident is an unexpected, unintended event that can cause bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care. Accident hazards include, but are not limited to, physical restraints, poorly maintained resident equipment, bathing facilities lacking non-slip surfaces, hazards such as electrical appliances with frayed wires, cleaning supplies easily accessible to cognitively impaired residents, wet floors that are not obviously labeled and to which access is not blocked, handrails not securely fixed to the wall, and water temperatures that can scald or harm residents. Purpose: to provide a safe and accident-free environment. Procedure: The facility is continuously monitored by all staff for unsafe/hazardous conditions, and corrections are promptly made as needed to maintain a safe environment for residents. Resident equipment is inspected regularly to ensure proper and safe working conditions. All residents are assessed quarterly for their risk of accidents and falls, and receive individualized care planning related to their individual needs		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure medications were labeled and administered according to the physician's orders for one of one (25) sampled resident who was administered lorazepam (an antianxiety medication) by one of one observed certified nursing assistant (CNA)/medication aide (MA) (M) from a medication blister pack (pre-formed plastic and foil packages that hold individual doses of pills or capsules in separate small pockets) with labeled administration instructions that did not match the physician's order for that medication in the resident's electronic medical record (EMR). Findings include: 1. Observation on 7/27/26 at 9:49 a.m. with certified nursing assistant (CNA)/medication aide (MA) M revealed that resident 25 received 0.5 milligrams (mg) of lorazepam along with other scheduled medications. CNA/MA M looked at the resident's physician order for lorazepam in her EMR and compared it to the resident's lorazepam medication blister pack card pharmacy label. She identified that the medication card's pharmacy label and the EMR had two different instructions for how often the medication was to be administered. Resident 25's lorazepam 0.5 mg EMR instructions indicated to give 1 tablet by mouth four times daily for anxiety disorder. The resident's lorazepam 0.5 mg medication card pharmacy label instructed to give one tablet by mouth two times daily. CNA/MA M stated, That is weird and administered one 0.5mg lorazepam tablet to resident 25. 2. Review of resident 25's EMR revealed that she admitted to the facility on [DATE]. She had orders for hospice services on 6/26/26. Resident 25 was started on 0.5mg lorazepam medication on 4/23/26, with the physician's order instructions to give one tablet by mouth two times daily. The physician's order was changed on 6/28/26, with the instructions to give one tablet by mouth three times daily. The lorazepam medication was changed by her provider again on 7/9/26, with the instructions to give one tablet by mouth four times daily. 3. Interview on 7/27/26 at 4:11 p.m. with registered nurse (RN) Q revealed that if an order for a controlled (a drug that the government regulates because it can be misused, cause physical or psychological dependence, or lead to an overdose) medication like lorazepam was changed, two nurses were expected to destroy the tablets in that medication's blister pack card and then order a new card from the pharmacy with the updated instructions. 4. Observation and interview on 7/28/26 at 3:23 p.m. of the medication cart from resident 25's hallway with director of nursing (DON) B revealed that resident 25 had three medication cards of 0.5 mg lorazepam tablets. All three of those medication cards were labeled with the instructions to give one tablet by mouth two times daily. DON B stated that two nurses were to destroy the medications if the medication order was discontinued. If the medication administration instructions changed, she expected staff to add a sticker on the medication card to indicate that those instructions had changed. The staff would then order a new medication card when medication supply in the card with the previous instructions ran out. She stated that resident 25's three medication cards should have had two stickers on the prescription label, one for when it changed from twice daily to three times daily, and another for when it changed from three times daily to four times daily. She would have expected staff to apply those stickers. 5. Review of the provider's 4/20/26 General Medication Administration policy and procedure revealed that during the medication pass, the staff was expected to check if there is a discrepancy between the card, label, and MAR, hold the medication until the medication pass is completed and verify with the physician's order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Aurora Brule Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 408 South Johnston Street White Lake, SD 57383	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the provider failed to ensure that the staff followed standard safe food service practices regarding handwashing and glove use when handling ready-to-eat (RTE) foods by one of one dietary aide (L) during one of two meals observed. Findings include: 1. Observation during lunch on 7/28/26 from 11:52 a.m. to 12:12 p.m. in the kitchen revealed that the menu was chicken parmesan with noodles, lettuce salad, peaches in yogurt, and a slice of buttered bread. Dietary aide L was responsible for dishing the lettuce salad onto the plates, placing a plastic cup of salad dressing on the plates, and delivering the resident's meals using a pushcart. He used his right hand to scoop the lettuce salad onto the plates with a serving spoon, and he used his bare left hand to touch the salad so it would stay on the plate. He placed the plastic cups of salad dressing directly on top of the food on the plates, rather than on the side of the plate. He went back and forth from the kitchen to the dining room delivering the resident's meals at least five times and did not perform hand hygiene or put gloves on his hands during the above observations. 2. Interview on 7/28/26 at 12:12 p.m. with dietary aide L about the above observations revealed he confirmed he touched the lettuce salad with his bare hands and did not perform hand hygiene or put gloves on before touching the lettuce salad with his hands. 3. Interview on 7/28/26 at 2:46 p.m. with certified dietary manager E revealed that he expected the staff to not touch RTE foods with their bare hands. He expected the staff to use serving utensils or perform hand hygiene and put gloves on when touching RTE foods. He did not realize the potential food contamination that could occur by placing the salad dressing cups directly on top of food. He expected the staff to perform hand hygiene each time they entered and exited the kitchen. 4. Review of the provider's 4/8/26 Food Preparation and Handling Policy revealed that foods are prepared and served with clean tongs, scoops, forks, spoons, spatulas, knives, plastic gloves, or other suitable implements to minimize handling and to avoid manual contact of food at all points during preparation and service. 5. Review of the provider's 4/8/26 Glove Use in Dietary policy revealed that the employees will wear gloves when handling any ready to eat foods like salad bar items, produce, sandwiches, cooked foods, deli meats, cheeses, breads, and ice.		

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NAME OF PROVIDER OR SUPPLIER Aurora Brule Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 408 South Johnston Street White Lake, SD 57383	
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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the provider failed to ensure the required Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Centers for Medicare and Medicaid Services (CMS) Part A form (CMS-10055) was provided for two of three sampled residents (26 and 43) reviewed for notification of Medicare benefits ending or their representatives to inform residents of potential financial liability for non-covered Skilled Nursing Facility (SNF) Part A services. Findings included: 1. Review of resident 26's electronic medical record (EMR) revealed that resident 26's Medicare Part A Skilled Services Episode start date was 5/6/26. Resident 26's last covered day of Part A was 7/23/26. The facility provided residents 26 and 43 the CMS^R^131 form, which is not the correct notice for SNF non-coverage. The CMS^R^131 form in the in resident 26's EMR was not signed by the resident or the resident's representative; instead, a phone consent was given on 7/20/26. There was no documentation indicating the correct SNF Advance Beneficiary Notice of Non-coverage (ABN) CMS^10055 form was explained, issued, or given to resident 26 or the resident's representative. 2. Review of resident 43's EMR revealed that resident 43's Medicare Part A Skilled Services Episode start date was 12/16/25. Resident 43's last covered day of Part A was 1/7/26. The facility provided the CMS^R^131 form, which is not the correct notice for SNF non-coverage. The CMS^R^131 form in the EMR was signed by the resident on 1/5/26. There was no documentation indicating the correct SNF ABN CMS^10055 form was explained, issued, or given to resident 43 or their representative. 3. Interview on 07/28/2026 at 9:50 a.m. with Administrator A confirmed the CMS^R^131 form was used instead of the CMS-10055 form and acknowledged they did not have a signed CMS^10055 for resident 26 or resident 43.		

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NAME OF PROVIDER OR SUPPLIER Aurora Brule Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 408 South Johnston Street White Lake, SD 57383	
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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview, record review, resident admission packet review, and policy review, the provider failed to ensure the binding arbitration agreement forms provided to residents or their representatives for review and signature contained the required information for one of one sampled resident (25).Findings include:1. Interview on 7/27/26 at 12:32 p.m. with business manager W revealed that she was assigned to develop and implement a binding arbitration agreement policy for the facility in January 2026. The policy was approved in March 2026, and only one resident's representative had signed an arbitration agreement form since then. Resident 25's representative signed the resident's arbitration agreement form.2. Review of resident 25's signed binding arbitration agreement form revealed that it was signed by the resident's representative on 4/22/26. The agreement form did not include the following required items: that the resident or their representative have the right to rescind the agreement within 30 calendar days of signing the form; that the resident or their representative is not required to sign the agreement as a condition of admission to the facility or as a requirement to continue to receive care at the facility.3. Phone interview on 7/29/26 with resident 25's legal representative revealed that she understood the agreement in terms of she would try to work out disagreements or grievances with the provider rather than going over their head, such as submitting concerns to the state survey agency. She could not remember if the provider informed her that she was exempt from litigation by signing the agreement. She further explained that the provider might have explained that to her, but she could not remember that part explicitly.4. Interview on 7/29/26 at 12:57 p.m. with administrator A revealed that business manager W was responsible for the binding arbitration agreement process at the facility. However, she was unavailable that day to discuss the agreements process.5. Continued interview on 7/29/26 at 1:30 p.m. with administrator A revealed that she acknowledged that the facility's arbitration form that the residents or their representatives signed did not include some of the required information. She explained that their policy contained that information, but the form that was given to residents or their representatives did not.6. Review of the provider's current admission packet revealed that a blank Arbitration Agreement form was included, but the policy that contained the required information was not included in that packet.7. Review of the provider's 3/18/26 Voluntary Binding Arbitration Agreement Policy revealed that it was the facility's policy to not require any resident or his/her representative to sign the VBAA [voluntary binding arbitration agreement] as a condition of admission to, or as a requirement to continue to receive care at the facility; provide the resident or his/her representative with a 30-day rescission period.		