

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	

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 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>Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to follow their policy to file an initial report to the SD DOH within two hours of an incident that involved a sampled resident (41) who had a behavioral event that required her to be placed into a manual hold by staff members according to their policy.</p> <p>Findings include:</p> <p>1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 41 revealed:</p> <p>*On 3/23/25 at 6:50 p.m., resident 41 was by an exit door in the Spruce 1 unit.</p> <p>-She had placed her belongings in front of that door earlier that afternoon.</p> <p>*Resident 41 walked down the hall to the exit door where her belongings were with a mental health aide.</p> <p>*Resident 41 became upset and struck out at a mental health aide who was in the area.</p> <p>*A second mental health aide came to assist.</p> <p>*A low-level manual hold (physical restraint where staff physically hold a resident to prevent movement, but do not use any mechanical devices or equipment) was placed on resident 41 by the two mental health aides, and they assisted resident 41 with walking to the dining room of the day hall.</p> <p>Resident 41 struggled near the day hall, and the CNAs then transitioned the hold to a medium-level manual hold physical intervention used to safely manage medium to high-risk behaviors in individuals experiencing a mental health crisis when other de-escalation techniques are not effective), then back to a low-level manual hold, and continued to assist resident 41 with walking to the dining area.</p> <p>-The hold ended at 6:56 p.m.</p> <p>*Registered nurse (RN) F was the nurse on duty at the time of the incident.</p> <p>-She had not notified any of the required individuals of the use of the manual holds at that time.</p> <p>*The initial and final report was filed with the SD DOH on 3/25/25 at 10:15 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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/5/25 at 10:16 a.m. with mental health aide N revealed:</p> <ul style="list-style-type: none"> *She worked for the provider for 31 years. *She had not had to use manual holds very often. *There are three types of manual holds: low, medium, and high (a manual hold is temporary and focuses on stabilization and ensuring the safety of the resident). <p>Interview on 6/5/25 at 10:34 a.m. with RN H regarding manual holds on residents revealed:</p> <ul style="list-style-type: none"> *Manual holds were used when a staff member needed to ensure their safety and/or a resident's safety, during forced cares (when a resident refuses care that their physician has ordered that they are required to receive, and the staff provides that care). *It was super rare that resident 41 required the use of a manual hold. *She received education on the approved manual holds every year and had completed the education last week. *The process for when a manual hold was used was to: <ul style="list-style-type: none"> -Notify the charge nurse or the nurse manager. -Notify the house supervisor if the hold was completed after normal business hours. -Complete an incident report. -Complete a note in the resident's electronic medical record. -Notify the physician. -The social worker or charge nurse was responsible for reporting the incident to the SD DOH. <p>Interview on 6/5/25 at 11:58 a.m. with geriatric program director of nursing (DON) B regarding the manual hold for resident 41 on 3/23/25 revealed:</p> <ul style="list-style-type: none"> *RN F had not documented or reported the manual hold used for resident 41 to the charge nurse or house supervisor. -RN F had not assessed resident 41 after the use of the manual hold and did not perform any nursing duties associated with the use of a manual hold. *The process for when a manual hold was used was to complete a restraint (manual hold) note, complete an assessment of the resident, and notify the house supervisor for a face-to-face assessment of the resident. -The house supervisor would document the face-to-face assessment in the resident's medical record. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*DON B was not aware that the report of the incident was filed on 3/25/25 to the SD DOH.</p> <p>-She had thought the report was completed on 3/24/25.</p> <p>-She confirmed that a report should have been filed with the SD DOH within two hours of the incident that required manual hold use for resident 41 on 3/23/25.</p> <p>*She confirmed the provider's Abuse and Neglect Policy related to reporting to the SD DOH had not been followed by RN F.*She confirmed the provider's Prevention of Mistreatment, Exploitation, Neglect and Abuse policy had not been followed for the reporting of the use of manual holds for resident 41 on 3/23/25 to the SD DOH within two hours.</p> <p>Review of the provider's undated Prevention of Mistreatment, Exploitation, Neglect and Abuse policy revealed:</p> <p>*An initial report shall be made within 2 hours of the event to the SD Department of Health.</p> <p>*Nurses shall assess, provide direction for care and monitor residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors .</p> <p>*Reporting: Nurse in charge at the time, Abuse Prevention Coordinator, Nurse Manager, or Program Director shall, within 24 hours, report all allegations of abuse, mistreatment or neglect of residents and misappropriation of resident property .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to follow standard of nursing practices to ensure assessments, physician notification, house supervisor notification to ensure a face-to-face assessment of the resident was completed, and documentation was entered in the resident's medical record regarding the use of manual holds for one of one sampled resident (41) was completed.</p> <p>Findings include:</p> <p>1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 41 revealed:</p> <p>*On 3/23/25 at 6:50 p.m., resident 41 was by an exit door in the Spruce 1 unit.</p> <p>-She had placed her belongings in front of that door earlier that afternoon.</p> <p>*Resident 41 walked down the hall to the exit door where her belongings were with a mental health aide.</p> <p>*Resident 41 became upset and struck out at the mental health aide.</p> <p>*A second mental health aide came to assist.</p> <p>*A low-level manual hold (physical restraint where staff physically hold a resident to prevent movement, but do not use any mechanical devices or equipment) was placed on resident 41 by the two mental health aides, and they assisted resident 41 with walking to the dining room of the day hall.</p> <p>-Resident 41 struggled near the day hall, and the mental health aides then transitioned the hold to a medium-level manual hold (physical intervention used to safely manage medium to high-risk behaviors in individuals experiencing a mental health crisis when other de-escalation techniques are not effective), then back to a low-level manual hold, and continued to assist resident 41 with walking to the dining area.</p> <p>-The hold ended at 6:56 p.m.</p> <p>*Registered nurse (RN) F was the nurse on duty at the time of the incident.</p> <p>-RN F indicated she had not assessed resident 41 after the use of the manual hold and did not perform any nursing duties associated with the manual hold.</p> <p>Review of resident 41's medical record revealed:</p> <p>*Her admission date was 3/12/25.</p> <p>*Her diagnoses included: major neurocognitive disorder due to another medical condition with behavioral disturbance and chronic kidney disease.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Her 3/19/25 Brief Interview of Mental Status assessment score was a 1, which indicated she had severe cognitive impairment.</p> <p>Interview on 6/5/25 at 10:34 a.m. with RN H regarding manual holds on residents revealed:</p> <p>*Manual holds were used when a staff member needed to ensure their safety and/or a resident's safety, during forced cares (when a resident refuses care that their physician has ordered that they are required to receive, and the staff provides that care).</p> <p>*It was super rare that resident 41 required the use of a manual hold.</p> <p>*She received education on the approved manual holds every year and had completed the education last week.</p> <p>*The process for when a manual hold was used was to:</p> <ul style="list-style-type: none"> -Notify the charge nurse or the nurse manager. -Notify the house supervisor if the hold was completed after normal business hours. -Complete an incident report. -Complete a note in the resident's electronic medical record. -Notify the physician. -The social worker or charge nurse was responsible for reporting the incident to the SD DOH. <p>Interview on 6/5/25 at 11:58 a.m. with director of nursing (DON) B regarding resident 41's manual hold on 3/23/25 revealed:</p> <p>*RN F was the nurse on duty on 3/23/25 when resident 41 required the use of a manual hold by staff members.</p> <p>*RN F had not documented or reported the manual hold used for resident 41 to the charge nurse or house supervisor.</p> <p>-RN F had not assessed resident 41 after the use of the manual hold and did not perform any nursing duties associated with the use of a manual hold.</p> <p>*The process for when a manual hold was used was to complete a restraint (manual hold) note, complete an assessment of the resident, notify the house supervisor for a face-to-face assessment of the resident, and notify the resident's physician.</p> <p>-The house supervisor would document the face-to-face assessment in the resident's medical record.</p> <p>Review of the provider's undated Physical Restraint Manual Restraint Policy revealed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*It shall be the policy of the SDHSC that manual restraint only be used to ensure the immediate physical safety of a patient, a staff member, or others and must be discontinued at the earliest possible time.</p> <p>*Types of physical restraints used at HSC includes a manual restraint such as forced procedure holds, and physical intervention holds.</p> <p>*Purpose</p> <p>-To provide an intervention when a patient's behavior indicates that he/she is in immediate danger of harming him/herself or others.</p> <p>*Manual Restraint: The use of one's hands and body to safely limit or restrict a patient's movement.</p> <p>*The RN shall notify the patient's physician or designee giving a detailed description of the situation necessitating the use of manual hold.</p> <p>*A face-to-face assessment shall be conducted by the physician or designee, or Face to Face RN within one (1) hour of initiation of physical restraint.</p> <p>*Assessment includes:</p> <p>-The patient's immediate situation;</p> <p>-The patient's reaction to the intervention;</p> <p>-The patient's medical and behavioral condition; and</p> <p>-The need to continue or terminate the restraint.</p> <p>*If a trained RN conducts the face-to-face evaluation following a Manual Hold and no further intervention or order for renewal is needed, the attending physician or designee will be notified of the hold and face to face evaluation the next working day.</p> <p>*This consultation shall include, at a minimum, a discussion of the findings of the evaluation, the need for other interventions or treatment, and the need to continue or discontinue the use of restraint.</p> <p>*Restraint/Seclusion event assessment will be documented by the assessing physician or designee or trained Face-to-Face RN.</p> <p>*The RN or designee shall notify the attending physician or designee of the use of manual restraint on the next working day .This review shall be documented in the patient's electronic health record with appropriate recommendations or modifications.</p> <p>*A RN shall document the patient's behaviors leading up to the restraint event and clinical assessment and rationale for use of a manual restraint.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD Human Services Center - Geriatric Program		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 Broadway Ave Yankton, SD 57078	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*A RN shall document the physician or designee, or face-to-face RN that was notified to complete the face-to-face assessment.</p> <p>*A RN shall document an assessment of the patient's mental and physical condition at least hourly or more frequently depending on patient need/condition or provider's orders.</p> <p>*The RN shall document an assessment and decision to discontinue the manual restraint along with the patient's physical condition, including vitals upon release from a manual restraint.</p> <p>Review of the provider's Documentation policy revealed All documentation shall be recorded as soon as possible after the occurrence.</p>