STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Platte Care Center	609 East 7th Platte, SD 57369

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on review of South Dakota Department of Health (SD DOH) complaint, interview, record review, and policy review, the provider failed to report suspected neglect for one of one (1) sampled residents. Findings include: 1. Review of the SD DOH complaint filed anonymously on 12/31/2025 revealed: *On 12/28/24, the anonymous writer observed resident 1 in a soiled (incontinent) brief after CNA D had documented changing resident 1's brief at 4:00 a.m. *The anonymous writer reported at 4:00 a.m., the brief was dated 0000 (indicating it was changed at 12:00 a.m.), concluding the brief could not have been changed at 2:00 a.m. by CNA D. *The anonymous writer reported that night shift staff had written multiple reports of CNA D's neglectful behavior, but the reports had not led to any change in CNA D's behaviors. 2. Review of the provider's [NAME] Care Center [NAME] Health Corrective Action Plan form submitted by LPN C revealed: *A CNA brought it to LPN C's attention that CNA D had not been completing required checks on residents but was falsely documenting she was. *LPN C verified one of the residents was incontinent of urine. *When LPN C confronted CNA D, CNA D told me [LPN C] I was in for a world of shit if reported. *CNA A felt she was being targeted by LPN C. *LPN C told CNA D she had been getting complaints from other CNAs alleging CNA D was not performing her job duties. *LPN C wanted to take a picture of a resident's incontinent brief, but CNA D would not allow this and made a scene. *LPN C then sent the DON a message to call and discuss the incident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Phone interview on 2/5/25 at 10:42 a.m. with a staff member who requested to remain anonymous revealed: *Some of the CNAs would lie about having completed their work duties. *CNA D had made verbal threats before to a night shift nurse. *The anonymous interviewee was aware of at least three staff members that had reported CNA D neglecting her duties to director of nursing (DON) B and administrator A. *The anonymous interviewee reported that staff are fearful of retaliation from management. 4. Interview on 2/5/25 at 12:07 p.m. with administrator A revealed: *He considered cares not getting done was neglect. *It was his expectation that if two staff did not get along or accused each other of abuse/neglect, the floor nurse was to investigate the allegations and report the investigation findings to DON B. *He reported education had been provided on how to file a report with the SD DOH to the nursing staff on 8/26/24 and to CNAs on 8/27/24 at staff meetings. *There were step-by-step instructions on how to file a report with the SD DOH in the medication room tip sheets binder. *It was his expectation that these allegations should have been reported to the SD DOH. 5. Interview on 2/5/25 at 2:31 p.m. with RN F regarding SD DOH online reporting revealed: *She was aware of the online reporting site. *She had used it to report fall incidents. *She had not used it to report allegations of neglect, she would report allegations of neglect directly to DON B for investigation. 6. Review of the provider's 1/2025 Abuse Prohibition Policy & Reporting of Crimes (in Long Term Care, Hospital, & Home Settings) policy revealed: *Neglect Neglect is the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. *The facility will thoroughly investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. *Policy: [NAME] Health Center [NAME] has established a zero tolerance policy for any form of abuse or neglect toward any resident/patient. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50915

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50915 Based on South Dakota Department of Health (SD DOH) complaint review, interview, record review, and policy review, the provider failed to thoroughly investigate allegations of neglect of one of one sampled resident (1) by certified nursing aide (CNA) D and failed to adequately document the process for reporting neglect. Findings include: 1. Review of the SD DOH complaint was anonymously on 12/31/2025 revealed: *On 12/28/24, the anonymous writer observed resident 1 in a soiled (incontinent) brief after CNA D had documented having changed resident 1's brief at 4:00 a.m. *The anonymous writer reported at 4:00 a.m., the resident's incontinence brief was dated 0000 (indicating it was changed at 12:00 a.m.), and concluded the brief could not have been changed at 2:00 a.m. by CNA D. *The anonymous writer reported that the night shift staff had written multiple reports of CNA D's neglectful behavior, but the reports had not led to any change in CNA D's behaviors. 2. Interview on 2/5/25 at 12:07 p.m. with administrator A revealed: *Reports of abuse or neglect were to be reported to the SD DOH by director of nursing (DON) B during daytime hours and by the night shift nurse during nighttime hours. *Instructions for reporting to the SD DOH could be found in the medication room in the tip sheet binder. *He described neglect to surveyors as cares not done. *It was his expectation that neglect allegations would be reported. *When asked if there had been any recent allegations of neglect, he replied There have been rumors. *When asked how he would have expected rumors of neglect to be handled, he explained he expected staff to report the allegations to the nurse. -The nurse was to then investigate the allegations. -He thought the last rumors of neglect had occurred about two or three months ago. *He was not aware of any written reports of neglect allegations. 3. Follow-up interview on 2/5/25 at 1:30 p.m. with administrator A revealed: *On 12/26/24, a [NAME] Care Center [NAME] Health Corrective Action Plan form had been submitted to DON B by licensed practical nurse (LPN) C regarding suspected neglect by CNA D. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*He had just received that form from DON B. *He was not aware that form had been received by DON B. *His statement regarding that form and the incident information included on it was It should have been reported. 4. Review of the provider's [NAME] Care Center [NAME] Health Corrective Action Plan form submitted by LPN C revealed: *A CNA had reported to LPN C's that CNA D had not been completing the required checks on residents and was falsely documenting that she had. *LPN C verified one of the residents had been incontinent of urine. *When LPN C confronted CNA D, CNA D replied CNA D told me [LPN C] I was in for a world of shit if reported to management for not performing her required duties. *CNA D felt she was being targeted by LPN C. *LPN C told CNA D she had been getting complaints from other CNAs alleging CNA D was not performing her job duties. *LPN C wanted to take a picture of a resident's incontinent brief, but CNA D would not allow that and made a scene. *LPN C then sent DON B a message to call and discuss the incident. 5. Interview on 2/5/25 at 2:10 p.m. with CNA E revealed: *If she witnessed abuse or neglect, she would first remove the resident from the immediate threat. *She would then report the abuse or neglect to the charge nurse. *It was her expectation that suspicion of abuse or neglect would be reported. 6. Interview on 2/5/25 at 2:47 p.m. with DON B revealed: *On the night of the above incident (12/26/26), she had missed a phone call from both LPN C and CNA D. *She later got a call from LPN F letting her know the [NAME] Care Center [NAME] Health Corrective Action Plan form had been placed on her desk. *The [NAME] Care Center [NAME] Health Corrective Action Plan form was placed on DON B's desk on 12/26/24 while DON B was on vacation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Upon her return from vacation, she interviewed CNA D about the accusation of not completing cares by LPN C. -CNA D was adamant her duties had been performed. *A follow-up communication with LPN C with the use of Volt (a messaging application on cell phone used by the facility for staff to communicate with each other) revealed CNA D had apologized to LPN C for yelling and refusing to talk to LPN C. *At this point, it was the DON's opinion the argument had been settled. 7. Review of the provider's 1/2025 Abuse Prohibition Policy & Reporting of Crimes (in Long Term Care, Hospital, & Home Settings) policy revealed: *Neglect Neglect is the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. *The facility will thoroughly investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. *Policy: [NAME] Health Center [NAME] has established a zero tolerance policy for any form of abuse or neglect toward any resident/patient.