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	02/04/2026

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 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. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, and record review, the provider failed to ensure one of one certified nursing assistant (CNA) (E) followed one of one resident (1) care plan when she left the resident alone in his room in his wheelchair. Resident 1 transferred himself to the toilet, fell, and experienced increased pain in his right leg. This citation is considered past noncompliance based on a review of the corrective actions the provider implemented following the incident. Findings include:1. Review of the SD DOH FRI revealed that on 1/16/26 at around 11:42 a.m., resident 1 was left alone in his room in his wheelchair after an activity. Activities CNA E wheeled resident 1 back to his room and left him sitting in his wheelchair with his call light within reach. The FRI indicated that CNA E did not read pocket care planner [a document that identifies a resident's care needs and interventions] which states Cannot be left alone in wheelchair in room. Resident 1 was found in his bathroom sitting on his wheelchair pedals. Resident 1 reported that he was trying to adjust his pants when his right leg gave out and he slid down his wheelchair and onto the foot pedals. He pulled the bathroom call light for assistance. He denied hitting his head. He was assisted off the floor and reported increased pain in his right leg. He could not bear weight on his right leg. He reported a 10 out of 10 pain rating and was sent to the emergency department. Resident 1 returned from the emergency department with no acute findings from the X-ray of his right thigh and pelvis, meaning there were no fractures. CNA E was interviewed regarding why she left [resident 1] in room unattended in wheelchair. [CNA E] stated she was not aware of [resident 1's] care plan. [CNA E] did have [the] pocket care planner on her per facility protocol and got it out and read it with [director of nursing services] and it did state in bold print that [resident 1] is not to be left alone. CNA E was re-educated about following the care plan since she was a newer employee at the time and does not work [CNA] Shifts, meaning she was primarily scheduled in the activities department versus as a direct care CNA. Resident 1 was ordered new pain control medications to help with any discomfort he is having following his fall. No changes were made to his care plan. Education was added to the daily taped report recording regarding resident 1's fall and to remind staff to follow the pocket care planner. 2. Interview on 2/3/26 at 3:26 p.m. with CNAs E and H revealed that they were full-time activity assistants, but they were also CNAs. They performed CNA duties like assisting residents with getting up and dressing in the mornings and helping residents to the bathroom. They were both aware of the pocket care plans and each had a copy with them. They learned of resident care plan updates, falls, and education each morning when they listened to the recorded nurse report. 3. Interview on 2/3/26 at 3:40 p.m. with resident 1 revealed he remembered falling a couple of weeks ago, but he could not remember what happened. He remembered feeling pain in his right leg. He confirmed he was not experiencing any more pain in his right leg from the fall. 4. Interviews with other residents (2, 3, and 4) throughout the survey from 2/3/26 to 2/4/26 who experienced recent falls revealed they had no concerns with the care they (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 0689 Level of Harm - Actual harm Residents Affected - Few	were receiving at the facility. 5. Interview on 2/4/26 at 9:55 a.m. with CNA E and activity assistant K revealed that they were aware of resident 1's fall that happened on 1/16/26. CNA E said, it was my fault. She explained that she is a new CNA and just passed her CNA test in December 2025. She worked full time in the activity department and did not usually work CNA shifts. She did not realize resident 1 was not supposed to be left alone in his room in his wheelchair. She had just taken him back to his room after an activity, and lunch was supposed to have been served soon so she thought that was a short enough time for him to sit in his wheelchair until someone could get him for lunch. She was provided with verbal education on using and following the pocket care plans after resident 1 fell on 1/16/26. 6. Interviews with other staff (CNAs F, G, and I, and activity assistant K) throughout the survey from 2/3/26 to 2/4/26 revealed they were all aware of resident 1's fall, they knew of his fall prevention interventions, they all had a copy of the pocket care plan with them, and they all listened to the recorded nurse's report at the start of each shift. 7. Interview on 2/4/26 at 10:29 a.m. with licensed practical nurse (LPN) C revealed that there was a voice recording device located in the nurse's station and a report binder that the charge nurses use to record updates. Staff were responsible for listening to the recorded report and reviewing the report binder at the start of each shift. Review of the report recording from the evening of 1/16/26 and 1/17/26 confirmed that resident 1's fall was talked about, and staff were reminded to have the pocket care plan with them, and to review the care plan if they had questions. Review of the report binder confirmed the same information was included for several days about resident 1's fall and about the pocket care plans. 8. Interview on 2/6/26 at 10:49 a.m. with director of nursing services (DNS) B revealed that audits on safe resident transfers and use of the pocket care plans had already been in place and were ongoing as a result of the provider's previous recertification survey. Audits consisted of observing nursing staff performing transfers on each resident at least once per month, ensuring that staff were following the resident's care plan, and ensuring that each nursing staff member had a copy of the pocket care plan with them. She explained that the pocket care plans were updated by the ward clerk any time a resident had a change in their electronic care plan. 9. Review of resident 1's electronic medical record (EMR) revealed that additional pain control medications were ordered after he returned from the emergency department on 1/16/26. His acetaminophen order remained the same. He had an order for Acetaminophen 650 mg [milligrams] PO [by mouth] 4XD [four times per day] PRN [as needed]. The acetaminophen was administered on 1/16/26 at 11:50 a.m., 1/16/26 at 2:45 p.m., 1/17/26 at 11:42 a.m., 1/17/26 at 1:38 p.m., 1/31/26 at 12:45 a.m., and 1/31/26 at 1:45 a.m. He had an order for Diclofenac 1% gel 2gm [gram] TOPICAL TID [three times a day] PRN [as needed] that was added on 1/16/26. Resident 1 had not yet used that pain control topical gel. He had an order for Lidocaine HCl 4% patch, 1 patch, apply to right thigh at 0600 [6:00 a.m.] and remove at 1800 [6:00 p.m.] that was ordered on 1/16/26. The patch did not start until 1/17/26 as there were no lidocaine patches on hand on 1/16/26. Resident 1 used the patch every day until it was discontinued on 1/21/26 at the resident's request. 10. Review of the 1/30/26 updated pocket care plan revealed that resident 1's section read, in bold letters, DO NOT LEAVE ALONE IN WHEELCHAIR IN HIS ROOM!!!!! 11. Review of the provider's 10/2024 Fall Risk Policy revealed that residents will be assessed for fall risk at regular intervals. Resident and Patient specific interventions will be implemented according to the results of the Fall Risk Assessment. The procedure included, Interventions will be resident and patient specific and appropriate for each situation. Resident Specific interventions will be documented in the [resident's] care plan. 12. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 2/4/26 after record review revealed the facility had followed their quality assurance (continued on next page)

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