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	11/05/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review, interview, and policy review, the provider failed to ensure informed consent was signed by one of three sampled resident (10) or a responsible party before administering a psychotropic (drug that affects brain activities associated with mental processes and behavior) medication.Findings include: 1. Review of resident 10's electronic medical record (EMR) revealed:*A diagnoses of hallucinations due to late onset dementia.*His daughter, who was his power of attorney, requested a medication to address the resident's increasing behaviors.*An order dated 8/7/25 to be given Quetiapine Fumarate (Seroquel) 25 milligrams by mouth at bedtime.*His care plan dated 10/22/25 indicated:-I will have no side effects of my psych [psychotropic] med [medication] noted.-My psychotropic med use will be reviewed per schedule and PRN [as needed] need.-Meds are reviewed by pharmacy/DON monthly, recommendations made to dr [doctor] as needed, review of meds at quarterly care conferences.-Psych med tracking done monthly by DON or selected nurse.-Mood observations every shift.-Family is informed of risks/benefits of treatment/potential of side effects of psych med.-Evaluated monthly vial pharmacy/DON review.*The EMR had no documentation that informed consent for the use of a psychoactive medication was provided to the resident or his daughter/POA. 2. Interview on 11/5/25 at 10:50 a.m. with social worker D revealed:*She was responsible for monitoring residents' psychotropic medications.*The provider received new informed consent forms that include the education of risks/benefits to use on 11/4/25. *Resident 10's daughter/POA requested the use of the Seroquel on 8/7/25.*Social Worker D verbally educated resident 10's daughter about the risks and benefits of psychotropic medication at that time. *There was a form used for informed consent before the new forms arrived that resident 10's daughter could have reviewed and signed.*She agreed there was no signed form for the informed consent for the use of the medication that was started on 8/7/25. 3. Interview on 11/5/2025 at 11:20 a.m. with director of nursing (DON) B revealed:*Social worker D tracked the documentation for psychotropic medications and consent forms that needed to be signed.*She knew there was a new form that was coming out soon.*She confirmed they had a form in place that residents/family should sign when a psychotropic medication was started.*She expected all residents on psychotropic medications to have signed consent documentation. 4. Interview on 11/5/2025 at 11:59 a.m. with administrator A revealed:*He was aware they were given new informed consent forms to use recently.*All residents/families should be provided education for psychotropic medications for consent for use before they were started.*He expected the forms to be signed and scanned into the resident EMR.*He agreed they should have provided resident 10's daughter/POA with the old form since the medication was started in August. 5. Review of the provider's May 2021 revised Psychoactive Drug Monitoring policy revealed:*The facility will provide a rationale for the use of the psychoactive drugs, which are prescribed. Either the facility will provide documentation from the record or from the physician that justifies the specific therapy.*The policy did not reference risk/benefit education or informed consent for the resident or family.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. Building B. Wing	11/05/2025

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 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 South Dakota Department of Health (SD DOH) Facility-Reported Incidents (FRI), record review, observation, interview, policy review, and job description review, the provider failed to ensure resident safety by:*One of one social worker (D) who did not provide supervision follow-up when the door alarmed for one of one sampled resident (19) who had eloped (left the facility without staff knowledge) and was outside the building for approximately five minutes without supervision.*Two of two certified nursing assistants (CNA) (G and H) who did not follow the care plan for one of one sampled resident (2) who required to be transferred by using two people, a gait belt, and a walker with manual transfers or one to two people using the sit-to-stand lift and fell. Findings include:1. Review of the provider's 6/17/25 SD DOH FRI revealed: *On 6/16/25 at 5:03 p.m. resident 19 exited the building through the east door. *Social worker D reset the door alarm at 5:04 p.m., looked down the hallway at the east door, where she saw a resident who was at risk for elopement and assumed he set the door alarm off. *Another resident came and notified social worker D that they saw resident 19 outside sitting on the bench and social worker D helped resident 19 back inside. 2. Review of resident 19's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had a Brief Interview of Mental Status (BIMS) assessment score of 4, which indicated his cognition was severely impaired. *He had a diagnosis of dementia (a group of symptoms affecting memory, thinking, and social abilities), a decline in vision and hearing, and had a high risk for falling. *Elopement assessments were completed on 12/11/24, 2/24/25, and 5/15/25 which indicated he was not a risk for elopement. *His elopement on 6/16/25 was documented and his care plan was updated to alert staff that he was at risk for elopement. *Interventions documented in his care plan to prevent further elopements included monitoring his whereabouts and completing assessments quarterly and PRN (as needed). 3. Observation on 11/4/25 at 9:07 a.m. of resident 19 revealed he was sitting in a chair sleeping by the nurse's station with his gait belt and walker beside him. 4. Interview on 11/4/25 at 9:16 a.m. with certified nursing assistant (CNA) J revealed: *Resident 19 has tried to get up by himself without staff assistance which he needed because he was unsteady. (continued on next page)

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	11/05/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She did not remember if the resident eloped, but thought he had an elopement protocol in place for him. 5. Observation and interview on 11/4/25 at 1:53 p.m. in resident 19's room revealed: *He was lying on his bed reading a newspaper, with his bed in the lowest position, and his call light within his reach. *He did not remember exiting the facility on 6/16/25. 6. Interview on 11/4/25 at 1:58 p.m. with CNA G revealed: *She was not working during the time of resident 19's elopement due to an injury. *She received education on elopements that had been assigned online for their annual education. *She stated resident 19 was at risk for elopement and that was indicated on his pocket care plan (a document that identifies residents' care needs and interventions). 7. Review of the pocket care plan revealed that it indicated resident 19 was an elopement risk, but it did not list any interventions to prevent him from elopement. 8. Interview on 11/5/25 at 10:50 a.m. with administrator A revealed: *They had staff meetings for CNA's and nurses where they were educated about the elopement that occurred on 6/16/25 and the updated elopement policy. *They taped staff meetings so if someone missed the meeting then they could listen to the recordings. *Director of nursing (DON) B had the meeting sign in sheets that indicated who received the education. *He expected that all staff members to check outside for residents if a door alarmed. 9. Interview on 11/5/25 at 10:59 a.m. with social worker D revealed: *On 6/16/25 she had reset the door alarm and then checked the east door, where she saw a resident who was at risk for elopement and assumed he set the door alarm off. *She did not check the outside area to ensure a resident did not leave the facility or was outside without supervision. *She received verbal education on 6/17/25 about checking the outside area to ensure a resident had not eloped when a door alarmed, as well as the elopement education provided in the Quality Assurance and Performance Improvement (QAPI) meeting on 6/20/25. 10. Interview and education documentation review on 11/5/25 at 11:19 a.m. with DON B revealed: (continued on next page)

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	11/05/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Education regarding the elopement on 6/16/25 was provided at the staff meetings. *Staff members who did not attend the staff meetings were to read the meeting minutes and the policy that was attached and sign the sheet to indicate they received the education. *She verified that two nurses' and seven CNAs' signatures were not on the education sign-in sheet. She confirmed those staff members had not received the elopement education after resident 19's 6/16/25 elopement, and had all worked since that incident. *She stated those staff members had received annual education regarding elopements the month prior to the 6/16/25 incident, and she thought that was sufficient. 11. Interview on 11/5/25 at 12:04 p.m. with administrator A revealed: *Four dietary staff members had not received the education regarding the elopement and had worked since the incident on 6/16/25. *Maintenance worker F was at the 6/20/25 QAPI meeting and received the education regarding the 6/16/25 elopement, but administrator A did not believe he provided that education to the housekeeping or laundry staff. *Administrator A was responsible for QAPI, and the facility's current performance improvement plan was focused on skin tears. *There was no plan for monitoring or performing any audits related to elopements. 12. Review of the provider's revised July 2025 Elopement Assessment and Handling of Eloped Residents policy revealed: *Responding to an actual elopement is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units. *If an employee observes a resident leaving the premises or suspects that a resident has left the facility grounds, the employee will get help from other staff members in the immediate vicinity to have them inform the charge nurse of what resident is leaving or can't be found. *It did not indicate staff should check the outside area for residents who may have left the facility after the door alarmed. 13. An interview on 11/3/25 at 2:26 p.m. with resident 2 revealed that he expressed the staff did not always use two people to transfer him, and those staff were mainly staff members from other states. He reported he usually used a machine to stand up and needed to have two people assist him, but sometimes they only used one person to transfer him. He reported his pain made it difficult for him to walk, and he had fallen without being injured. He stated that his pain was being addressed, and he had an appointment with the pain clinic soon. (continued on next page)

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	11/05/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14. Observation on 11/3/25 at 2:40 p.m. in resident 2's room revealed that contracted travel certified nursing assistant (CNA) H entered resident 2's room in response to his call light. Resident 2 wanted to transfer from his recliner to his wheelchair. Without applying a gait belt (a waist strap gripped as support for safe mobility and transfer), CNA H assisted resident 2 using a stand and pivot transfer technique (when assisted to a standing position, the resident then turns their body to move to another surface). 15. Review of resident 2's electronic medical record (EMR) revealed his 9/11/25 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact. He had diagnoses of: compression fracture of lumbar one vertebra (a break in one of the bones in the lower spine), spinal stenosis (a narrowing of the spinal canal), chronic low back pain, lumbar degenerative disc disease (wear and tear of spinal discs cushions between the vertebrae in the spine] in the lower back), chronic atrial fibrillation (irregular heart rhythm), anticoagulated on warfarin (taking a medication to slow blood clotting ability), Parkinson's disease (a progressive brain disorder that affects the nervous system, leading to a gradual decline in movement), and hypophonia (slurred speech secondary to Parkinson's disease.) He fell on 9/29/25 and 10/7/25 when he was walking with staff, while using a gait belt and a walker; His legs gave out, and they lowered him to the floor. He had orders for physical therapy (PT), occupational therapy (OT), speech therapy, and restorative therapy. His PT and OT notes from 9/12/25 to 10/31/25 did not address recommendations regarding how staff should transfer him. A 10/7/25 progress note from his primary physician indicated that nursing staff informed him they were transferring the resident with a sit-to-stand lift to help prevent future falls. That note stated, Patient is anticoagulated on warfarin for history of atrial fibrillation, so need to continue implementing safety measures to avoid falls. Resident 2's 9/11/25 care plan revealed staff were to: transfer-substantial/dependent x 2 assist with walker and gait belt-enc [encourage] him to get up slowly from sitting/lying position. May use standing [sit-to-stand] lift x1-2 [with one to two staff] assist [assistance]., Be alert to unsteady gait/standing balance deficits/pain/wt [weight] bearing and report variances., and Fall f/u [follow up] 10/7/25 resident 2 will be a x2 assist for all walking and manual transfers until staff feels Resident 2 is stronger. 16. Observation and interview on 11/4/25 at 8:43 a.m. with CNA G in Resident 2's room revealed CNA G assisted Resident 2 independently to transfer using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position). She did not apply the strap to secure his lower legs. The resident's knees slightly buckled, when being moved while standing in the lift, but he caught himself and stood up straighter. CNA G reported Resident 2 was to be transferred by one to two staff using the sit-to-stand lift or with two staff and a gait belt without a lift. She stated she should have used two people to transfer him with the lift since he dipped. She determined how many staff were needed to assist him when using the sit-to-stand lift by how he was feeling that day, and stated she would use two staff to assist him for the rest of the day. 17. Interview on 11/5/25 at 8:19 a.m. with CNA I revealed that staff would know how to transfer the residents by referring to the pocket care plans. (continued on next page)

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	11/05/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	18. Interview on 11/5/25 at 8:24 a.m. with Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator C revealed that resident 2 was care planned to be transferred with the assistance of two people, a gait belt, and a walker without a lift or one to two people while using the sit-to-stand lift. CNAs were not to determine how many staff were needed to transfer residents while using the sit-to-stand lift. She stated the nurse would have to direct the CNAs regarding that. 19. Interviews on 11/5/25 at 11:44 a.m. and at 12:40 p.m. with DON B revealed she expected CNA H to follow resident 2's care plan when transferring him and expected CNA G to use the leg strap on the sit-to-stand lift when transferring him to secure his lower legs. She stated she interviewed CNA H, and she had admitted that she did not follow the resident's care plan when transferring the resident. DON B stated she took her off the floor until an investigation was completed. DON B reported that to ensure contracted traveling staff competencies, the contracted CNA completed a facility checklist, and she reviewed those skills travel staff members completed with the travel staffing employment agency. She stated that all nursing staff competencies were to be completed by December 2025. They were last completed on 8/21/24. 20. Review of CNA H's training documentation revealed a training checklist indicated she completed training in accident prevention and safety procedures, abuse and neglect, and care of residents with unique needs on 9/24/25. She completed competencies regarding patient safety, patient fall prevention, and elderly abuse on 9/3/25 through her travel employment agency. 21. A review of the provider's 11/3/25 pocket care plan (a document that identifies residents' care needs and interventions) regarding resident 2 revealed it indicated staff were to: TRANSFER-substantial [significant physical support] x 2 assist or may use 1-2 with standing lift. Ambulate 2 assist Walker/gaitbelt to all meals, follow with wheelchair and sit when tired. 22. Review of the provider's December 2023 Lifting/transferring policy revealed the facility administrator is accountable for establishing policies, procedures, training and motivation to avoid injuries. Each facility should adopt and communicate safety policies and procedures to all staff. Safety is also a responsibility of every employee. 1. All nursing personnel will have annual in-services on the correct procedures for lifting and transferring, including the correct use of gait belts. 2. Gait belts: are to be used for transferring residents who are able to bear weight.4. Mechanical Stand may be 1 or 2 staff depending on resident needs and is to be used for partial or limited weight bearing residents in the following: A. Any resident who requires more than standby or contact guard assist as identified by therapists.C. Any resident who, because of their medical condition (MS, comatose, rigidity, etc.) are difficult to control during a transfer but can bear weight.