STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Chamberlain Care Center	300 S Byron Blvd Chamberlain, SD 57325

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 0600 Level of Harm - 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 South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, electronic medical record (EMR) review, video footage review, interview, and policy review, the provider failed to protect the resident's right to be free from physical abuse by: *One of one certified nursing assistant (CNA) (D) who responded to falling incidents with physical force and restraint for one of one sampled resident (1) with cognitive impairment. *Eight additional staff members (E, G, H, I, J, K, L, and M), identified as present at the time the physical abuse occurred, who did not intervene or report those incidents to a supervisor at the time those incidents occurred. Findings include: 1. Review of the provider's 4/7/25 SD DOH FRI revealed: *On 4/7/25, the provider reviewed video footage of resident 1's falls from 4/6/25. *The video footage revealed CNA D assisted [resident 1] roughly back into his wheelchair after he had fallen. *CNA D pushed him [resident 1] up to the desk and locked the brakes on his wheelchair so he was not able to move around . *CNA D did not get the nurse when he fell to do an assessment. *[The] Nurse completed [an] assessment on 4/7/2025 and [resident 1] has some bruises on his arms. *Resident 1 was showing signs of increased anxiety during his interactions with CNA [D]. *CNA D did state that she did become frustrated . and should have stepped away. *[Licensed practical nurse (LPN) J] stated that she was in report [staff communication of residents' status] when these events took place, and no one reported these events until after report. (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 0600 Level of Harm - Actual harm Residents Affected - Few	*On 4/14/25, when interviewed by director of nursing (DON) B and licensed social worker (LSW) O, Certified medication assistant (CMA) I reported that CNA D had transferred [resident 1] back into his wheelchair after his fall without the nurse assessing him first. *CMA I noted that [CNA D] was laughing at [resident 1's] statements, but did not recall any specific instances where [CNA D] was rough with [resident 1]. *Education was immediately [on 4/7/25] provided to all nurses and CNAs regarding proper procedures after a fall, including notifying the nurse of the fall so they can complete an assessment . All staff was [were] also educated on proper times to lock wheels on wheelchairs, and safely transferring residents. *Resident cares with [resident 1] will also be audited randomly for the next 2 months and then prn [as needed] to ensure appropriate interactions from staff. *New staff will be trained upon hire on managing residents with dementia. *CNA D was terminated immediately after her interview on 4/7/25, no longer allowing her to provide resident care at that facility. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 3/28/25 Minimum Data Set (MDS) assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *His diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (a mental state where a person loses touch with reality), mood disturbance (a serious mental illness that causes persistent and intense changes in a person's mood energy and behavior), general anxiety disorder, Alzheimer's Disease, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), and conduct disorder (a mental health condition that involves a persistent pattern of aggressive and antisocial behavior). *His care plan indicated, Inappropriate behaviors related to dementia. He demonstrates behaviors which include restlessness, wandering, combative, resists cares, verbally abusive, disruptive to other[s], [and] varying mood. -His care plan Approaches included: --Resident will have 2 staff assist [assistance of two staff] with cares when given due to aggressive behaviors. --If [Resident 1] becomes restless try these [non]pharmacological interventions like having the dog sit with him, wheel him around the facility in his wheelchair, visiting with him in a quiet setting or listening to calming music, resting on the couch in dining room with lights lowered and giving him snacks or something to drink. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	--When approaching [resident 1] come from the front and not behind or on his sides as this can startle him. *Resident 1 was out of the facility and unavailable for interview throughout the survey. 3. Interview and review of the 4/6/25 video footage on 6/12/25 at 10:12 a.m. with director of finance N, DON B, and LSW O revealed: *Resident 1 fell on 4/6/25 at 12:45 p.m., 6:04 p.m., 6:12 p.m., and at 6:51 p.m. *At 12:45 p.m., resident 1 stood up from his Broda Pedal Wheelchair (a specialized high-back reclining wheelchair with upper body support that allows a person to self-propel with their hands or feet) that was positioned at the counter in front of the nurses' station. CNA D approached resident 1. Resident 1 swung his arm at her. CNA D stepped back, and resident 1 fell to the floor. -Without requesting assistance or notifying a nurse, CNA D reached around resident 1 and, from the back, grabbed both of his forearms, lifted him off the floor by herself while he was fighting her, and placed him into the wheelchair forcefully. Her movements were quick and rough. She placed his wheelchair at the counter and locked his wheelchair brakes, which prevented him from moving his wheelchair. -CNA M, LPN J, and nutrition and food services supervisor L were all visible on the video footage present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *At 6:04 p.m., resident 1, positioned at the nurses' station, stood up from his wheelchair and fell to the floor. CNA D was seen from behind the wheelchair, extending resident 1's arms above his head as he lay on the floor. Without requesting assistance or notifying a nurse, CNA D then stood beside resident 1, placed her arms behind him, attempted to hoist him back into his wheelchair, and lifted him from the floor multiple times before seating him roughly into the wheelchair while he resisted her assistance. -CMA G, CNA H, and food service assistant E were all visible on the video footage and present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *At 6:12 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a third time. Without requesting assistance or notifying a nurse, CNA D lifted resident 1 from the floor and sat him roughly into the wheelchair while he resisted her assistance. -CMA I, CNA D, and food service assistant E were all visible on the video footage and present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *At 6:50 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a fourth time. He was provided with a pillow, by a staff member and was not observed having been assessed by the nurse or assisted off the floor in that video footage. -He threw the pillow at the staff member and remained on the floor for approximately an hour. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-CMA G, CNA K, CNA H, LPN J, and food service assistant E were all visible on the video footage and present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *CNA D's employment was terminated on 4/7/25 for her actions observed in the video footage immediately after the footage had been reviewed by management on 4/7/25. *CNA K had been a contracted travel employee and was unavailable for interview. Her contract had ended. *CNA H had been a contracted travel employee and was unavailable for interview. Her contract had been terminated due to another incident. *LPN J had been a contracted travel employee and was unavailable for interview. She had terminated her contract three or four days after the incident with resident 1 on 4/6/25. 4. Interview on 6/12/25 at 8:42 a.m. with CMA Q revealed she had recently received training on fall protocols, but did not recall any recent training on abuse and neglect. She completed abuse and neglect training when she was hired and annually online in the Success Center. 5. Interview on 6/12/25 at 9:31 a.m. with LSW O regarding staff training and education revealed: *Monthly All Staff Meetings were mandatory. -Employees were allowed to attend in person, by phone, via a WebEX (an online meeting platform) or were required to read and sign the attendance sheet before their next working shift. *The monthly staff meeting binder was kept in the employee break room. *New employee orientation and annual education were provided on the provider's online Success Center. -Those trainings were assigned by corporate. *Training was also provided in person, by text, and by email. 6. Interview on 6/12/25 at 1:07 p.m. with CMA G revealed she: *Stated she had not worked on 4/6/25, the day that resident 1 had fallen four times. *Did not recall any times that CNA D had been rough when providing care to resident 1. *Had not attended any recent training on abuse, neglect, or falls. *CMA G was seen in the video footage of 4/6/25 at 12:45 p.m., at 6:04 p.m., and at 6:51 p.m. 7. Interview on 6/12/25 at 2:19 p.m. with LSW O revealed she: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*Assisted with the completion of audits and had not been aware of any current audits of resident 1's care. *Was unaware that the FRI had indicated, Resident cares with [resident 1] will also be audited randomly for the next 2 months and then prn [as needed] to ensure appropriate interactions from staff. 8. Interview on 6/12/25 at 2:23 p.m. with DON B revealed: *On 4/7/25 administrator A, DON B, director of finance N, and LSW O had reviewed the video footage of resident 1's 4/6/25 falls. -They felt that the video was embarrassing, and had shown everything that should not have been done. --The footage revealed CNA D had been really rough with resident 1 and had locked his wheelchair while it was positioned at the nurse's station. --LPN J had been present on the video footage on 4/6/25 at 12:45 p.m. and 6:51 p.m. and had not assessed resident 1 after his falling incidents. *An assessment of resident 1 had been completed on 4/7/25 after review of the video by Minimum Data Set (MDS) registered nurse (RN) C and DON B, and they had confirmed that bruises on resident 1's forearms correlated with where CNA D had placed her hands while lifting resident 1 after his falls. *The video verified abuse had occurred, and CNA D's agency [travel] employment contract had been terminated immediately. *Education had been provided to LPN J on 4/7/25 on proper transfer techniques and completing a resident assessment after a fall. *In-person staff education was initiated on 4/7/25 on not locking wheelchair brakes, ensuring an assessment was performed by a nurse before transferring a resident after a fall, and proper transfer techniques. *Education on resident abuse and neglect was provided through the online Success Center during orientation and annually. -There had not been any recent training provided on resident abuse and neglect. *Dementia training was ongoing, and a training was scheduled in July with the local ombudsman (resident rights advocate). *DON B expected CNA D to have: -Alerted the nurse when resident 1 fell. -Ensured that resident 1 had been assessed by the nurse before she transferred resident 1 back into his wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Asked for assistance when transferring resident 1. -Requested another staff member to take over when she became frustrated with resident 1. *DON B expected the other staff members identified as present when the incidents in the video occurred to have: -Assisted when resident 1 fell. -Stopped CNA D when she attempted to transfer resident 1 alone. -Alerted the nurse when resident 1 fell to complete an assessment to ensure he was not injured. -Attempted other interventions to prevent him from falling. -Contacted him to report the incident. *He was unaware that the FRI had indicated, Resident cares with [resident 1] will also be audited randomly for the next 2 months and then prn [as needed] to ensure appropriate interactions from staff. An interview with CMA I was requested and set up for 6/12/25 at 3:00 p.m. A voicemail was left, and no return call was received. All Staff training completed since 4/1/25, including materials provided and staff who attended, including any additional PRN training/education completed, was requested from administrator A and DON B during the survey entrance conference. Review of the provider's staff training/education documentation since 4/1/25 revealed: *Education on Timeliness of DOH Reports was provided to four employees between 4/28/25 and 5/5/25 and one employee on an undisclosed date. *Neuro [assessment of nervous system function] Vital [vital signs such as blood pressure, temperature, pulse, respirations, and blood oxygen level] Documentation (Falls) education was provided to: -Two employees in December 2024. -Twelve employees in January 2025. -One employee in February 2025. -Two employees in March 2025. *A Falls Investigation packet did not identify the date the training was provided or include a signature sheet for attendance. *The provider's All Staff Meeting Binder revealed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The 4/24/25 Care Center Monthly Meeting Agenda did not include education on the topics of abuse or neglect. -Out of 66 employees, 33 had attended the meeting or signed that they had reviewed the information in the binder. *The 5/30/25 Care Center Monthly Meeting Agenda did not include education on the topics of abuse or neglect. -Out of 45 employees, 18 had attended the meeting or signed that they had reviewed the information in the binder. *The provider's In Person Dementia Training education staff attendance sheets from 1/8/25 through 5/27/25 did not include documentation of the content of the education provided in that training. *The provider's Ombudsman Dementia Training education staff attendance sheets from 1/28/25 through 5/29/25 did not include documentation of the content of the education provided in that training. *LPN J received training on 4/7/25 on proper assessment techniques after a resident fall, that included resident 1 should have been helped back up to his wheelchair immediately after [an] assessment [of the resident had been completed], not left to lay on the floor .for nearly an hour, and ensuring brakes are not locked on wheelchair that is a restraint . -That training did not include resident abuse and neglect. *Education dated 4/7/25 included notify the nurse immediately so they can assess the resident for injury, and brakes also should not be locked when a resident's wheelchair is stationary, that is considered a restraint, was provided to 26 employees between 4/7/25 and 4/18/25. -Food service assistant E, nutrition and food services supervisor L, and CNA M had not received that education. Interview on 6/12/25 at 4:00 p.m. with executive assistant P regarding abuse and neglect training revealed: *Abuse and neglect training was provided to staff on the Success Center online learning platform. *CNA D was a contracted travel employee from 2/24/25 until 4/8/25 and had not received abuse and neglect training. *CNA H was a contracted travel employee from 4/2/25 until 4/14/25 and had not received abuse and neglect training. *CNA K was a contracted travel employee from 2/26/25 until 5/24/25 and had not received abuse and neglect training. *LPN J was a contracted travel employee from 2/13/25 until 4/9/25 and had not received abuse and neglect training. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*Food service assistant E was hired on 8/23/21. Executive assistant P was unable to find documentation that food service assistant E had received abuse and neglect training. *Nutrition and food services supervisor L was hired on 9/19/11. Executive assistant P was unable to find documentation that nutrition and food services supervisor L had received abuse and neglect training. *CNA M was hired on 2/19/25 and received abuse and neglect training on 2/20/25. *CMA G was hired on 5/28/19 and had received abuse and neglect training on 3/8/25. *CMA I was hired on 3/18/24 and received abuse and neglect training on 2/4/25. Review of the provider's 7/10/24 Abuse and Neglect policy revealed: *Patients and residents have the right to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of property, corporal punishment, exploitation and involuntary seclusion. *Patients and residents must not be subject to any kind of abuse by anyone, but not limited to, facility staff, other patients or residents, consultants, volunteer staff or other agencies serving the individual, family members, legal guardians or personal representatives, friends, or other individuals. *Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. This presumes that instances of abuse of all patients and residents even those in a coma, cause physical harm or pain or mental anguish. *Physical Abuse includes .restraining or confining a patient/resident to control behavior . *Policy To require facility staff to report suspected abuse or neglect of vulnerable adults. *All persons who have reasonable cause to believe a resident/patient of this facility is being subjected to abuse and/or neglect .are responsible to report such suspicions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure care plans were reviewed and revised to reflect the current care needs for two of two sampled residents (1 and 2). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 3/28/25 Minimum Data Set (MDS) assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *His diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (a mental state where a person loses touch with reality), mood disturbance (a serious mental illness that causes persistent and intense changes in a person's mood energy and behavior), general anxiety disorder, Alzheimer's Disease, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), and conduct disorder (a mental health condition that involves a persistent pattern of aggressive and antisocial behavior). *Resident 1 experienced 15 falls between 3/11/25 and 5/7/25. *Five of resident 1's falls occurred on or before 4/6/25. Review of resident 1's Fall Risk Assessments indicated: *On 4/6/25, he had a high risk for falls, and a referral to a Falls Prevention Program may be appropriate, and Continue Current Plan of Care were marked. -Resident 1 fell four times between 4/7/25 and 4/15/25. *On 4/15/25, he had a high risk for falls, and No Referrals Necessary, and Continue Current Plan of Care were marked. -Resident 1 fell four times between 4/16/25 and 4/26/25. *On 4/26/25, he had a high risk for falls, and a referral to a Falls Prevention Program may be appropriate, and Continue Current Plan of Care were marked. -Resident 1 fell two times between 4/27/25 and 5/7/25. *On 5/7/25, he had a high risk for falls, and a referral to a Falls Prevention Program may be appropriate, and Plan of Care Updated, and safety signs in room were marked. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At least eight of resident 1's falls occurred outside of his room. Review of resident 1's fall incident reports and interventions implemented to prevent subsequent falls revealed: *On 4/6/25 at 12:40 p.m., staff were to keep resident 1 in Line of sight for the next couple of hours. *On 4/6/25 at 6:10 p.m., 6:15 p.m., and 6:20 p.m., 4/14/25 at 11:40 a.m., and 12:25 p.m., no documented interventions were put in place. *On 4/15/25 at 11:00 a.m. and 4:00 p.m., UNKNOWN was indicated. *On 4/16/25, resident 1 was agitated and left alone on floor with [a] pillow per [his] care plan. -No other documented intervention was put in place at that time to prevent him from subsequent falls. *On 4/26/25, We let resident [1] lay on the floor until he was ready to get up was documented. -No other intervention was put in place at that time to prevent him from subsequent falls. -On 5/7/25 at 2:45 p.m., Safety signs placed was documented. Review of resident 1's Post-Fall Investigation Tool Recommendations for future prevention revealed: *On 4/14/25 at 11:40 a.m. and 12:25 p.m., 4/15/25 at 4:00 p.m., 4/16/25, 4/18/25, 4/26/25, 4/22/25, and 5/5/25 that section had not been completed. *On 4/15/25 at 11:00 a.m. Quit isolating dementia Pts [patients] was documented. *On 5/7/25, Signs in room was documented. Review of resident 1's care plan revealed: *A problem area indicated Falls [resident 1] at risk for falling R/T [related to] dementia, incontinence, and ambulatory status was last reviewed/revised on 4/24/25. -A 5/7/25 Approach (intervention) indicated Posted signs or pictures to cue [resident] for toileting /assistance prior to [the resident] getting up. -A 4/7/25 Approach indicated Provide toileting assistance every 2-3 [two to three] hrs [hours] while awake and PRN [as needed]. --Resident 1 was Dependent [on the] assistance x2 [of two staff members] for walking on/off unit. --Resident 1 was Able to pedal [his wheelchair] with [his] feet [for] short distances. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Resident 1 was Dependent [on the] assistance x 1-2 [of one to two staff members] for toileting. *Resident 1's care plan had not been updated with fall prevention interventions after falling incidents that occurred between 4/7/25 and 5/7/25. He had experienced nine falls during that time. Resident 1 was out of the facility and unavailable for an interview throughout the survey. 2. Review of the provider's 6/1/25 SD DOH FRI revealed: *[Resident 2] was found on [the] floor at 1910 [7:10 p.m.] by a CNA .he was attempting to self transfer out of wheelchair by [his room]. *Resident 2 sustained a closed fracture of [his] left hip. *Before the fall, resident 2 was changed from [needing to use] a stand aid [a mechanical device that lifts a resident from a sitting position to a standing position] to a stand pivot with two [staff] assist [assistance]. Observation and interview on 6/11/25 at 11:10 a.m. with resident 2 revealed: *He was seated in his recliner, fully reclined, holding a cup of water with a straw. *He answered questions with one to two words, smiled, and laughed. *There was no air mattress overlay on his bed. Review of resident 2's EMR revealed: *He was admitted on [DATE] and received hospice services from 2/17/25 until 5/10/25. *Resident 2 had been evaluated by physical therapy (PT) on 5/15/25. *His 5/23/25 MDS assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *A 5/27/25 PT progress note indicated .will change program to add SPT [stand pivot transfer] in addition to stand aid until all staff [are] more comfortable with transfer and staff are aware. *Resident 2 fell on 5/29/25. *A 5/29/25 Fall Risk Assessment indicated resident 2 was Not at Risk for falls and to Continue with Plan of Care. *His 5/29/25 fall incident report did not indicate any interventions were implemented or revised to prevent subsequent falls. *Resident 2's Post-Fall Investigation Tool Recommendations for future prevention revealed toilet more frequently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Chamberlain Care Center	300 S Byron Blvd Chamberlain, SD 57325

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-His care plan was not updated to include that intervention. *Resident 2 fell on 6/1/25 and sustained a closed fracture of his left hip and was hospitalized . *He was readmitted to the facility on [DATE] and admitted to Hospice Services that same day. Review of resident 2's current care plan revealed: *A 3/5/25 last reviewed/revised problem area of ADL's Functional Status with approaches that indicated: Transfers Dependent x2 [on the assistance of two staff members] for transfers using [a] Hoyer lift [a mechanical lift and sling used to lift a person's full body] to/from toilet, recliner . *A 3/5/25 last reviewed/revised problem area of Falls [resident 2] has a history of falling and is at risk for injury from fall with Approaches that indicated: Posey bed alarm system activated while in bed. Keep bed in low position. Provide proper, well-maintained footwear. Provide resident [2] an environment free of clutter. *A 2/17/25 initiated problem area Terminal Care [resident 2] is on [provider name] Hospice d/t [due to] terminal prognosis of Alzheimer's Disease. That was last reviewed/revised on 3/14/25 with an approach that indicated: -Air mattress overlay .to prevent skin breakdown while in bed. *His care plan had not been updated to indicate: -His transfer status had changed to a stand pivot transfer on 5/27/25. Any new or revised fall prevention interventions after his 5/29/25 fall. He had been admitted to hospice services on 6/5/25. He did not have an air mattress overlay on his bed. 3. Interview on 6/11/25 at 2:08 p.m. with CNA R regarding resident 2 revealed: *Resident 2 was on hospice. *CNA R used the care plan located in the EMR system to know how to care for resident 2. 4. Observation and interview on 6/12/25 at 8:42 a.m. with resident 2 and CNA Q revealed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*CNA Q confirmed resident 2 did not have an air mattress or overlay on his bed. -She indicated he had one when he had previously received hospice services, but it had been removed. *CNA Q used the care plan in their EMR system to know how to care for resident 2. 5. Phone interview on 6/12/25 at 11:19 a.m. with registered nurse (RN) F revealed: *After a resident fell, the staff members on duty would have a post-fall huddle to discuss the fall and how to prevent further falls (interventions). *The post-fall sheet had a place to indicate new interventions. *Minimum Data Set (MDS) RN C updated the care plans. *A list of fall interventions had been posted at the nurses' station recently, and nurses had been told that they needed to update the residents' care plans after each fall. *He had not received education on how to update the care plan. *He would email MDS RN C to let her know if they had tried a new intervention. *He would look in the residents' EMR for their care plans, but he was not sure where the CNAs would find the interventions since they had stopped using pocket care plans (a portable document that outlines a resident's care needs). 6. Interview on 6/12/25 at 1:35 p.m. with MDS RN C regarding resident care plans revealed: *Each department was responsible for its portion of a resident's care plan. *She updated the nursing sections of the resident's care plan when she completed the MDS and expected all nurses to update the care plans as changes occurred. *Staff had been educated on updating care plans in January 2025. *She had posted a laminated list of fall interventions at each nurse's station for the nurses to reference when they updated the resident care plans after a fall. *She expected that resident 2's care plan would have been updated when he was discharged from hospice services in May. *She expected the resident care plans to be updated in real time to reflect the resident's current care needs. *She acknowledged that resident 1 and 2's care plans did not reflect their current care needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Interview on 6/12/25 at 2:23 p.m. with director of nursing (DON) B regarding resident care plans revealed he expected care plans to be updated to reflect the resident's current care needs. Review of the provider's 1/31/25 Comprehensive Care Plan and Care Conferences policy revealed: *To develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychosocial well-being. *The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with the standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life. *Person-centered care - To focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. * .The care plans must be revised as the resident's needs/status changes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, record review, and interview, the provider failed to implement, review and revise interventions to reduce the risk of falls for two of two sampled residents (1 and 2) with a history of falls and to prevent subsequent falls. Findings Include: 1. Review of the provider's 6/1/25 SD DOH FRI revealed: *[Resident 2] was found on [the] floor at 1910 [7:10 p.m.] by a CNA [certified nursing assistant] .he was attempting to self transfer out of wheelchair by [his room]. *Resident 2 sustained a closed fracture of [his] left hip. *Before the fall, resident 2 was changed from [needing to use] a stand aid [a mechanical device that lifts a resident from a sitting position to a standing position] to a stand pivot with two [staff] assist [assistance]. Interview and review of the 6/1/25 video footage on 6/12/25 at 10:12 a.m. with director of finance N, director of nursing (DON) B, and licensed social worker (LSW) O revealed: *Resident 2 was seated in his wheelchair by certified medication assistant (CMA) G at her medication cart two minutes before he fell. *CMA G entered a resident's room across from her medication cart, and resident 2 propelled himself in his wheelchair down the hall. Used the railing in the hallway, stood from his wheelchair, took approximately six to eight small steps, and fell. *Registered nurse (RN) F responded and provided care to resident 2. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on [DATE] and received hospice services from 2/17/25 until 5/10/25. *Resident 2 had been evaluated by physical therapy (PT) on 5/15/25. *His 5/23/25 MDS assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *A 5/27/25 PT progress note indicated .will change program to add SPT [stand pivot transfer] in addition to stand aid until all staff [are] more comfortable with transfer and staff are aware. *Resident 2 fell on 5/29/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*A 5/29/25 Fall Risk Assessment indicated resident 2 was Not at Risk for falls and to Continue with Plan of Care. *His 5/29/25 fall incident report did not indicate any interventions were implemented or revised to prevent subsequent falls. *Resident 2's Post-Fall Investigation Tool Recommendations for future prevention revealed toilet more frequently. -His care plan was not updated to include that intervention. *Resident 2 fell on 6/1/25 and sustained a closed fracture of his left hip and was hospitalized . *He was readmitted to the facility on [DATE] and admitted to Hospice Services that same day. Review of resident 2's current care plan revealed: *A 3/5/25 last reviewed/revised problem area of ADL's Functional Status with approaches that indicated: Transfers Dependent x2 [on the assistance of two staff members] for transfers using [a] Hoyer lift [a mechanical lift and sling used to lift a person's full body] to/from toilet, recliner . *A 3/5/25 last reviewed/revised problem area of Falls [resident 2] has a history of falling and is at risk for injury from fall with Approaches that indicated: Posey bed alarm system [a device used to alert caregivers when a resident attempts to exit their bed, designed to help prevent falls] activated while in bed. Keep bed in low position. Provide proper, well-maintained footwear. Provide resident [2] an environment free of clutter. *A 2/17/25 initiated problem area Terminal Care [resident 2] is on [provider name] Hospice d/t [due to] terminal prognosis of Alzheimer's Disease. That was last reviewed/revised on 3/14/25 with an approach that indicated: -Air mattress overlay .to prevent skin breakdown while in bed. *His care plan had not been updated to indicate: -His transfer status had changed to a stand pivot transfer on 5/27/25. Any new or revised fall prevention interventions after his 5/29/25 fall. He had been admitted to hospice services on 6/5/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	He did not have an air mattress overlay on his bed. 2. Interview and review of the 4/6/25 video footage on 6/12/25 at 10:12 a.m. with director of finance N, DON B, and LSW O revealed: *Resident 1 fell on 4/6/25 at 12:45 p.m., 6:04 p.m., 6:12 p.m., and at 6:51 p.m. *At 12:45 p.m., resident 1 stood up from his Broda Pedal Wheelchair (a specialized high-back reclining wheelchair with upper body support that allows a person to self-propel with their hands or feet) that was positioned at the counter in front of the nurses' station. CNA D approached resident 1. Resident 1 swung his arm at her. CNA D stepped back, and resident 1 fell to the floor. -Without requesting assistance or notifying a nurse, CNA D reached around resident 1 and, from the back, grabbed both of his forearms, lifted him off the floor by herself while he was fighting her, and placed him into the wheelchair forcefully. Her movements were quick and rough. She placed his wheelchair at the counter and locked his wheelchair brakes, which prevented him from moving his wheelchair. *At 6:04 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and fell to the floor. CNA D was seen from behind the wheelchair, extending resident 1's arms above his head as he lay on the floor. Without requesting assistance or notifying a nurse, CNA D then stood beside resident 1, placed her arms behind him, attempted to hoist him back into his wheelchair, and lifted him from the floor multiple times before seating him roughly into the wheelchair while he resisted her assistance. *At 6:12 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a third time. Without requesting assistance or notifying a nurse, CNA D lifted resident 1 from the floor and sat him roughly into the wheelchair while he resisted her assistance. *At 6:50 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a fourth time. He was provided with a pillow, by a staff member and was not observed having been assessed by the nurse or assisted off the floor in that video footage. *After each fall observed on that video footage, resident 1 was returned to his wheelchair and positioned facing the counter at the nurses' station. No new interventions were implemented to prevent subsequent falls. Review of resident 1's EMR revealed: *He was admitted on [DATE]. *His 3/28/25 MDS assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*His diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (a mental state where a person loses touch with reality), mood disturbance (a serious mental illness that causes persistent and intense changes in a person's mood energy and behavior), general anxiety disorder, Alzheimer's Disease, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), and conduct disorder (a mental health condition that involves a persistent pattern of aggressive and antisocial behavior). *Resident 1 experienced 15 falls between 3/11/25 and 5/7/25. *Five of resident 1's falls occurred on or before 4/6/25. Review of resident 1's Fall Risk Assessments indicated: *On 4/6/25, he had a high risk for falls, and a referral to a Falls Prevention Program may be appropriate, and Continue Current Plan of Care were marked. -Resident 1 fell four times between 4/7/25 and 4/15/25. *On 4/15/25, he had a high risk for falls, and No Referrals Necessary, and Continue Current Plan of Care were marked. -Resident 1 fell four times between 4/16/25 and 4/26/25. *On 4/26/25, he had a high risk for falls, and a referral to a Falls Prevention Program may be appropriate, and Continue Current Plan of Care were marked. -Resident 1 fell two times between 4/27/25 and 5/7/25. *On 5/7/25, he had a high risk for falls, and a referral to a Falls Prevention Program may be appropriate, and Plan of Care Updated, and safety signs in room were marked. -At least eight of resident 1's falls occurred outside of his room. Review of resident 1's fall incident reports and interventions implemented to prevent subsequent falls revealed: *On 4/6/25 at 12:40 p.m., staff were to keep resident 1 in Line of sight for the next couple of hours. *On 4/6/25 at 6:10 p.m., 6:15 p.m., and 6:20 p.m., 4/14/25 at 11:40 a.m., and 12:25 p.m., no documented interventions were put in place. *On 4/15/25 at 11:00 a.m. and 4:00 p.m., UNKNOWN was indicated. *On 4/16/25, resident 1 was agitated and left alone on floor with [a] pillow per [his] care plan. -No other documented intervention was put in place at that time to prevent him from subsequent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*On 4/26/25, We let resident [1] lay on the floor until he was ready to get up was documented. -No other intervention was put in place at that time to prevent him from subsequent falls. -On 5/7/25 at 2:45 p.m., Safety signs placed was documented. Review of resident 1's Post-Fall Investigation Tool Recommendations for future prevention revealed: *On 4/14/25 at 11:40 a.m. and 12:25 p.m., 4/15/25 at 4:00 p.m., 4/16/25, 4/18/25, 4/26/25, 4/22/25, and 5/5/25 that section had not been completed. *On 4/15/25 at 11:00 a.m. Quit isolating dementia Pts [patients] was documented. *On 5/7/25, Signs in room was documented. Review of resident 1's care plan revealed: *A problem area indicated Falls [resident 1] at risk for falling R/T [related to] dementia, incontinence, and ambulatory status was last reviewed/revised on 4/24/25. -A 5/7/25 Approach (intervention) indicated Posted signs or pictures to cue [resident] for toileting /assistance prior to [the resident] getting up. -A 4/7/25 Approach indicated Provide toileting assistance every 2-3 [two to three] hrs [hours] while awake and PRN [as needed]. --Resident 1 was Dependent [on the] assistance x2 [of two staff members] for walking on/off unit. --Resident 1 was Able to pedal [his wheelchair] with [his] feet [for] short distances. --Resident 1 was Dependent [on the] assistance x 1-2 [of one to two staff members] for toileting. *Resident 1's care plan had not been updated with interventions to reduce his risk for falls after he fell nine times between 4/7/25 and 5/7/25. 3. Phone interview on 6/12/25 at 11:19 a.m. with RN F revealed: *Resident 1 had many falls. *He was the nurse on duty when resident 2 fell on 6/1/25. *CMA G had been with resident 2 just before he fell and had called him to assess resident 2 after he fell on 6/1/25. *After a resident fell, the staff members on duty would have a post-fall huddle (meeting) to discuss the fall and how to prevent further falls. *The post-fall sheet had a place to indicate new interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*A list of fall interventions had been posted at the nurses' station recently, and nurses had been told that they needed to update the residents' care plans after each fall. *He had not received education on how to update the care plan. *He would email MDS RN C to let her know if they had tried a new intervention. *He would look in the residents' EMR for their care plans, but he was not sure where the CNAs would find the interventions since they had stopped using pocket care plans (a portable document that outlines a resident's care needs). 4. Interview on 6/12/25 at 1:07 p.m. with CMA G revealed she: *Had not attended any recent training on preventing falls. *Had worked on 6/1/25 when resident 2 fell. *Recalled resident 2 had been with her at her medication cart at the end of the hall. The resident in the room across from her was standing in his room. She entered that resident's room to assist that resident and heard resident 2 fall. *She had only been away from resident 2 a couple of minutes before he fell. *She was unsure how resident 2 transferred or when he had been last used the bathroom before his fall. *The nurse would give a verbal a report, or the CNAs would do walking rounds to share resident status information. *She does not look at the care plan in the EMR and was not sure where to locate resident fall interventions. 5. Interview on 6/12/25 at 1:35 p.m. with MDS RN C regarding resident fall interventions revealed: *She had posted a laminated list of fall interventions at each nurse's station for nurses to reference when they updated the resident care plans after a fall. *She expected new interventions to be implemented and added to the resident care plans in real time after a resident's fall to reduce the resident's risk for falls. 6. Interview on 6/12/25 at 2:23 p.m. with DON B regarding fall interventions revealed he expected care plans to be updated with new fall interventions after a resident had a fall to reduce the resident's risk for falls. Review of the provider's 3/1/24 Fall Prevention & Follow-Up Reporting policy revealed: *The interdisciplinary team will review and discuss [fall] preventatives at weekly Mini-Managers meetings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*The QMI [quality management and improvement Committee will review resident falls every month to determine what new, preventative [fall] measures [interventions] should be put in place.