STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A139	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flandreau Santee Sioux Tribe Care Center	909 Jones Dr Flandreau, SD 57028

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the South Dakota Department of Health (SD DOH) complaint intake report review, interview, security video review, record review, and policy review, the provider failed to ensure one of one certified nursing assistant (D) safely transported one of one sampled resident (1) in her wheelchair who fell out of her wheelchair and fractured her hip.Findings include:1. Review of the 9/10/25 SD DOH complaint intake report revealed the provider and Adult Protective Services (APS) reported resident 1 fell from her wheelchair to the SD DOH.The SD DOH facility-reported incident (FRI), received on 8/30/25, indicated that on 8/29/25 at around 8:00 p.m., while certified nursing assistant (CNA) D was transporting two residents in their wheelchairs, resident 1's wheelchair brake caught on the activity room window frame. She fell out of her wheelchair and complained of pain in her right hip and right foot. Resident 1 was transported to the emergency department where it was confirmed that she fractured her right hip. The provider re-educated staff in regards to proper movement with wheelchairs.The APS report, received on 9/8/25, revealed that on 8/29/25, CNA D was transporting resident 1 and another resident in their wheelchairs to the designated smoking area. Resident 1 was ran into the wall which resulted in resident 1's right hip fracture. Four people lifted resident 1 up from the floor and threw her onto the gurney to be transported to the emergency department. Resident 1 had emergency surgery on 8/30/25 to correct the hip fracture. 2. Interview on 9/30/25 at 9:12 a.m. with resident 1 revealed that on 8/28/25, CNA D was pushing her and another resident at the same time out to the smoking area. Resident 1 felt that CNA D was not paying attention to where he was pushing her. Her wheelchair got too close to the wall of windows, and something caught on the window frame. She fell out of her wheelchair and as soon as I [resident 1] hit that wall, I felt my hip pop.Resident 1 said that CNA D attempted to pick her up from the floor, but she told him that she was in too much pain. She said that she was hollering. Once other staff arrived, they tried to pick her up off the floor to sit her in her wheelchair, but she was in too much pain to move. The ambulance was called. Two ambulance staff and two CNAs helped lift her onto the ambulance gurney.While at the hospital, it was confirmed that she had fractured her right hip. She had corrective surgery and was readmitted back to the nursing home. She explained that she had rheumatoid arthritis, a disease that affected her joints and caused contractures (permanent tightening of muscles or joints) in her hands and knees. The fall and hip fracture were painful, and she continued to experience pain in her hip after she returned to the nursing home.Since returning to the nursing home, she felt increased anxiety and wanted to talk with someone about her side of the story. She became tearful as she felt that no one wanted to talk to her about the accident. She confirmed she continued to go out to smoke every day. She had to close her eyes and tensed up as she was transported past the area where she fell, as she was fearful of falling again.She confirmed that CNA D still worked at the facility. She did not fear him. She did not feel like he did it on purpose and that it was an accident. She indicated that she was okay with CNA D continuing to help care for her. 3. Interviews with a random sample of residents throughout the facility confirmed no other concerns with staff providing their care. 4. Interview on 9/30/25 at 11:00 a.m. with licensed practical nurse (LPN) E revealed that she was a contracted travel nurse and had not heard about the above accident. She could not recall receiving any recent education about safe resident transporting expectations. She did not know where to find the provider's policy on what to do in the event of a resident fall, but she was able to verbalize understanding of the proper nursing procedures following a resident fall. When she started her contract at that facility, she received a week of mentored training to learn the normal facility routines and procedures. 5. Interview on 9/30/25 at 11:16 a.m. with CNA F and CNA K revealed that neither of them had been at the facility when the above accident happened, but they heard about it when they came back to work. They both confirmed that they did not receive any follow-up education about the fall policy or safe resident transporting expectations. CNA F indicated the report she received about the accident was more of an FYI [for your information]. Continued interview on 9/30/25 at 11:20 a.m. with CNA F individually revealed she heard that CNA D was pushing two residents in their wheelchairs at the same time. She indicated that was not the proper procedure and it was safer to push one resident at a time in a wheelchair. CNA F confirmed she knew where to find the facility policies and procedures regarding falls, accidents, and other topics. She was able to point out where the policies were located. 6. Interview on 9/30/25 at 11:39 a.m. with certified medication aide (CMA) G and CNA H revealed that neither of them was at the facility when the above accident occurred. They did not receive a briefing or report about the accident