South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11055	A. BUILDING: ______ B. WING ______	C 02/19/2026

NAME OF PROVIDER OR SUPPLIER: **EDGEWOOD GREENLEAF BROOKINGS LLC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2015 8TH STREET SOUTH, BROOKINGS, SD 57006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 2/17/26 through 2/19/26. Edgewood Greenleaf Brookings LLC was found not in compliance with the following requirements: S080, S095, S096, S105, S115, S130, S131, S165, S275, S280, S295, S305, S330, S331, S405, S450, S465, S474, S489, S652, S685, S820, and S850. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 2/17/26 through 2/19/26. Areas surveyed included nursing services, quality of care, and resident safety related to a resident who received a hot liquid burn injury. Edgewood Greenleaf Brookings, LLC was found not in compliance with the following requirements: S030, S165 and S405.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report any of the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and or other critical equipment	S 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Moechnig, Regional — TITLE — (X6) DATE: 3/26/26

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S 030	Continued From page 1 necessary for operation of the facility for more than twenty-four hours;. (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation of the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event. This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure one of one allegation of potential resident abuse or neglect was reported to the South Dakota Department of Health (SD DOH) within the required timeframe and a thorough investigation completed for one of one resident (10) who sustained a hot liquid burn to her leg. Findings include: 1. Review of the 4/22/25 SD DOH FRI revealed: *On 4/3/25 at 11:30 a.m., resident 10 sustained a "hot liquid burn to the medial aspect [middle] of her left thigh" when she reached for her soup and knocked the bowl of soup into her lap. *The soup temperature was 171 degrees. *"Wound treatments and skin monitoring continued through 4/21/25."	S 030	RND provided education to the ED/RN/LPN completing of the online reporting DOH system for reportable incidents. Policies on incident reporting were reviewed. No changes or revisions needed. The CSD or designee is responsible for completing the reportable incidents. Audits implemented on all incidents that required online state reporting to be reviewed by ED to audit timeliness and status of report. ED will take to QA meeting for review monthly x 2 months, then quarterly thereafter.	3/19/2026

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*"Staff will assist [resident 1] with locating her food due to her visual impairment to help prevent future accidents."
*The SD DOH FRI was submitted on 4/22/25, 19 days after the incident occurred.
*Further documentation was requested at the time of the report and was not provided.

2. On 2/18/26 at 1:36 p.m., a request was made to executive director A for all documentation related to the incident on 4/3/25 related to resident 10's hot liquid burn incident.

3. Review of resident 10's care record revealed:
*She was admitted to the facility on 1/2/25.
*There was no documentation on 4/3/25 regarding resident 10 sustaining a burn, whether vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) had been taken, or whether an initial assessment of the injury had been completed. There was no documentation on whether the resident's family or provider had been notified of the injury.
*A 4/4/25 nursing progress note indicated "Medical Doctor Appointment Referral: Reason: second degree burn to left thigh."
*There was no documentation that an investigation was completed related to the burn injury.

4. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed:
*She was not responsible for submitting the report of resident 10's hot liquid burn to the SD DOH or investigating that incident. The former executive director completed the investigations and reporting to SD DOH, but was no longer employed at the facility.
*DON B saw resident 10's burn approximately

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two days after the incident and described the burn as a large burn with several blisters on the resident's left thigh.
*She expected that resident 10's burn injury would have been documented in her EMR when it occurred, reported to the SD DOH within 24 hours of the incident, and that an investigation would have occurred related to how resident 10 had sustained that burn.
*DON B was unaware that the burn had not been reported to the SD DOH until 4/22/25.
*DON B was unsure if an investigation into resident 10's hot liquid burn had occurred.
*DON B stated she provided all the records related to resident 10's hot liquid burn that she could find, but she had not found an investigation into how the burn had occurred.

5. Interview on 2/19/26 at 2:10 p.m. with executive director A revealed:
*Resident 10 was discharged from the facility before she was hired as the executive director at the facility in August 2025.
*She was unaware that resident 10 had sustained a hot liquid injury, nor was she aware of any documentation of an investigation into that incident.
*She expected that the incident would have been reported to the SD DOH within 24 hours of resident 10 having been burned and an investigation completed for that injury.

6. Review of the provider's January 2019 Electronic Incident Reporting Tips policy revealed:
*"When an incident occurs, the original paper resident incident report should be completed by whomever has first-hand knowledge of the event. It should then be given to the supervisor, who should fill out the electronic incident report."
*" Critical ...injuries that are the result of faulty

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S 030	Continued From page 4 equipment or possible negligence." *There was no documentation regarding investigating or reporting incidents to the SD DOH.	S 030		
S 080	44:70:02:02 Pets No pet kept in or visiting a facility may negatively affect the well-being of any resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to provide proof of vaccination and that the animal was free from disease for one of one resident-owned pet that resided in the facility. Findings include: 1. Observation and interview on 2/17/26 at 1:45 p.m. with residents 2 and resident 6 in their shared room revealed: *They had moved into the facility about 9 months ago with their pet cat. *They were unsure if the cats' vaccination and veterinary records were at the facility or had been provided to the facility when they moved in. 2. Interview on 2/19/26 at 2:05 p.m. with executive director A regarding resident 2 and resident 6's pet cat revealed: *The facility allowed resident pets, and residents were required to sign a pet agreement. *She expected records of pet vaccination and health records to be available at the facility and reached out to resident 2 and resident 6s' daughter to inquire if those records were	S 080	ED has received current vaccination records for pet and has been uploaded into the resident chart. Pet Policy was reviewed and no changes/revisions were necessary	3/19/26

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S 080	Continued From page 5	S 080		

available.
*No documentation of resident 2 and resident 6's pet cat's vaccination and veterinary records had been located.

3. Review of the provider's April 2014 Pet Agreement revealed:
*"I will keep my pet current on vaccinations and have documentation from a veterinarian that the pet is healthy and disease-free."

4. Review of the provider's May 2021 Assisted Living Resident Handbook revealed:
*"All pets must have up to date vaccinations and copies of those vaccinations will be kept in the resident's chart."
S080
Based on observation, interview, and record review, the provider failed to provide proof of vaccination and that the animal was free from disease for one of one resident-owned pet.

Findings include:

1. Observation and interview on 2/17/26 at 1:45 p.m. with residents 2 and 6 in their shared room revealed:
*They had moved into the facility about 9 months ago with their pet cat.
*They were unsure if the cats' vaccination and veterinary records were at the facility or had been provided to the facility when they moved in.

2. Interview on 2/19/26 at 2:05 p.m. with executive director A regarding resident 2 and 6's pet cat revealed:
*The facility allowed resident pets, and residents were required to sign a pet agreement.
*She expected records of pet vaccination and health records to be available at the facility and

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S 080	Continued From page 6 reached out to resident 2 and 6s' daughter to inquire if those records were available. *No documentation of resident 2 and 6's pet cats' vaccination and veterinary records had been located. 3. Review of the provider's April 2014 Pet Agreement revealed: *"I will keep my pet current on vaccinations and have documentation from a veterinarian that the pet is healthy and disease-free." 4. Review of the provider's September 2025 admission agreement revealed: *"All pets must have up to date vaccinations and copies of those vaccinations will be kept in the resident's chart."	S 080		
S 095	44:70:02:05 Housekeeping Cleaning Methods And Equipment The facility shall establish written housekeeping procedures for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to ensure housekeeping policies were available to one of one housekeeper (H) who did not speak or read English.	S 095	Education was provided to housekeeping staff by Executive Director. Reference binders will be available on the housekeeping cart as well as reference materials in housekeepers preferred language. Policies were reviewed and no changes/revisions were necessary	4/10/26

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S 095	Continued From page 7	S 095		

Findings include:

1. Observation and interview on 2/19/26 at 11:18 a.m. with housekeeper H in the housekeeping closet revealed:
*She spoke limited English and used an app on her phone to translate and communicate with others.
*She had worked at the facility for two years.
*There were no written housekeeping procedures for the cleaning of all areas of the facility, nor were there facility policies available to her in Spanish. She did not think that she needed written information about cleaning the facility because she had been trained how to clean the facility and resident rooms when she was hired by another housekeeper.
*She was able to read the labels of the chemicals they used because they were in both English and Spanish.

2. Refer to S096.

3. Interview on 2/19/26 at 2:05 p.m. with executive director A revealed:
*Housekeeper H did not speak English, and there was a language barrier in her communication with others.
*She thought housekeeper H was provided with policies and educational information in Spanish when she was hired.
*She was unaware that the facility's policies and procedures for cleaning the facility were unavailable at the facility to housekeeper H, in the language she spoke and read.

S 096	44:70:02:05 Housekeeping Cleaning Methods And Equipment	S 096		

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S 096	Continued From page 8 Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to secure two of two observed germicidal wipe containers in the memory care unit and ensure one of one housekeeping cart was secured by one of one housekeeper (H) in the assisted living wing. Findings include: 1. Observation on 2/17/26 at 3:05 p.m. and again on 2/19/26 at 8:40 a.m. revealed: *There were two bottles of Medline Microkill Two germicidal wipes sitting on the top shelf of the staff station in the memory care unit. -A warning label was present on the bottle to keep out of reach of children. -The active ingredient in the wipes was isopropyl alcohol (a substance that is toxic to humans if swallowed). *They were located just outside of the main dining area. *The residents who resided in this unit were moderately to severely cognitively impaired. -The current census was 19.	S 096	New cleaning carts were ordered on 2/23/26. These were delivered and are being utilized on both sides of our building. These include locked bins for staff to lock all chemicals. Education will be provided by ED to all staff at next all staff meeting on all cleaning products that direct care staff utilize. Policies on hazardous materials was reviewed and no revisions needed. The Executive Director will complete weekly audit times one month and quarterly for 6 months to ensure that hazardous chemicals are secured at all times. The Executive Director will review audits at the monthly QA meeting.	4/10/2026

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2. Interview on 2/19/26 at 9:30 a.m. with director of nursing (DON) B revealed that the germicidal wipes should not have been left unsecured in a unit with multiple cognitively impaired residents to have access to them.

3. Observation on 2/19/26 at 11:18 a.m. with housekeeper H in the assisted living wing revealed:
*Housekeeper H stocked the housekeeping cart with supplies to clean a resident's room.
*She left the housekeeping cart unattended outside of the housekeeping closet across from the kitchen while she gathered items to stock on the cart.
*Housekeeper H entered resident 5's room to clean the bathroom and left the housekeeping cart unattended in the hallway during that time.
*The cart contained the following hazardous chemicals and hazardous products: room freshener, Febreeze air mist, glass cleaner, toilet bowl cleaner, Bio-enzymatic odor eliminator, a rapid multi-surface disinfectant, and disinfectant wipes, which contained a warning label to keep them out of reach of children.

4. Interview on 2/19/26 at 11:40 a.m. with housekeeper H revealed:
*She spoke Spanish and used an app on her phone to translate and communicate with others.
*The housekeeping cart she used did not have a cabinet or a lock on it. The chemicals were stored and unsecured on the cart in the hallways while she cleaned resident rooms.
*She thought that the residents in the assisted living wing knew not to touch the chemicals on the housekeeping cart.

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S 096	Continued From page 10 5. Observation and interview on 2/19/26 at 11:58 a.m. with executive director A in the assisted living hallway outside resident 8's room revealed: *She confirmed the housekeeping cart was unsecured and unattended. *Residents with cognitive impairment lived in the assisted living wing of the facility. *She was unaware that the housekeeping cart did not have a cabinet or lock to secure the chemicals. *She expected the housekeeping cart to be attended to, in the resident's room with housekeeper H while she cleaned the resident's room, or in the locked housekeeping closet to ensure the safe storage of chemicals. 6. On 2/19/26 at 2:10 p.m. executive director A was requested to provide a chemical storage policy, and a policy was not provided before the survey exit.	S 096		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, documentation review, and policy review, the provider failed to follow standard food safety practices related to	S 105	All dietary staff received education on proper food storage and handling, as well as proper sanitation. Policies on proper food storage and handling were reviewed with no revisions necessary. The cooks are responsible for completing temperature logs daily. DSD will review temp logs weekly for compliance. DSD will audit food labeling, storage and cleaning weekly x 1 month and then quarterly for 6 months. DSD will present findings at the monthly QI meeting.	4/10/26

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monitoring the dishwasher temperatures, implementing safe food storage and labeling practices, and maintaining the cleanliness of two of two sampled kitchens.

Findings include:

1. Observation on 2/17/26 at 3:15 p.m. of the refrigerator in the memory care unit kitchen revealed the presence of:
*A covered storage dish containing several servings of unidentified food.
-There was no date on that item.
*A covered storage dish that contained shredded lettuce.
-There was no date on that item.
*A covered storage dish that contained sliced peaches.
-The item had a use-by date marked as 2/12/26.
*A Styrofoam container containing a piece of pie.
-It was labeled with a resident's name.
-There was no date on the item.
*The following opened condiments:
-Two bottles of yellow mustard that did not have an open date and had expired on 7/31/24 and 6/10/25.
-One bottle of ketchup that did not have an open date and had an unknown expiration date.
-One bottle of cocktail sauce that did not have an open date and expired on 6/28/25.
-One bottle of caramel sauce that did not have an open date and had expired on 6/21/25.
-One bottle of chocolate sauce that did not have an open date and had an unknown expiration date.
-Four bottles from the facility that each contained ranch dressing, french dressing, barbecue sauce, and maple syrup. They did not have an open date or expiration date.
*A 20-ounce bottle of orange soda that was half

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full. It was unknown who the drink belonged to or when it had been opened.
*A 20-ounce bottle of an electrolyte drink that was half full. It was unknown who the drink belonged to or when it had been opened.
*The freezer section of the refrigerator contained:.
-An off-white substance over a large portion of the bottom of the freezer that resembled melted ice cream. There were also multiple brown particles on the floor of the freezer.
*The seal on each of the doors contained a dark colored debris.

2. Observation on 2/17/26 at 3:54 p.m. of the main kitchen revealed:
*Fifteen small bowls of grapes were uncovered on a rolling cart.
*There were papers taped above the hand-washing sink that were not cleanable. The tape securing them was peeling and discolored, and there were dried residual water splash marks on the sheets of paper.
*The top of the dishwashing machine was covered with crumbs and unidentifiable debris. Water scale and lime build up was visible on the side, top, and below the dishwashing machine. The floor below the dishwashing machine was dirty with crumbs and water stains.
*Food debris, including what appeared to be scrambled eggs, was on the floor under the stove and in the serving area.
*A step stool and the right side of the stove had black substance drip marks that appeared to be grease.
*The floor to the right of the stove contained a lid to a pan and was dirty with food crumbs and pieces of what appeared to be paper. The substances on the floor were brown and black

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S 105	Continued From page 13 and appeared sticky. *The kitchen refrigerator thermometer indicated the temperature inside the refrigerator was 43 degrees Fahrenheit (°F). That refrigerator contained: -An open, unlabeled plastic bag of cheese dated "2/8." -An open, undated, unlabeled plastic bag of cheese cubes. -An open jar of salsa dated "8/29." -A yellow-brown hard piece of fruit that appeared to be a lemon. -An undated, unlabeled plastic bag of what appeared to be sliced deli ham. The contents appeared slimy. -A shopping bag contained a zip bag of brown and green celery sticks that appeared rotten, and a covered glass bowl of a green and white food substance. -An open, undated container of yogurt. *The large refrigerator in the Pantry contained: -An undated, unlabeled plastic container of unidentified cubed food. -Open undated bags of shredded cheese. -Two undated, unlabeled plastic "to go" style containers of food. 3. Observation and interview on 2/17/25 at 4:05 p.m., with cook D in the main kitchen revealed: *Cook H placed a pan in the dishwasher. She thought the dishwasher was both a high-temperature and a chemical-sanitizing dishwasher. She was unsure what temperature the dishwasher needed to reach and did not record dishwashing temperatures. -The dishwasher temperature reached a temperature of 170 degrees during the observation. *Cook H stated that there were no logs for her to record the level of sanitizer in the sani-bucket, or	S 105		

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the dishwasher, refrigerator, freezer, or food temperatures, but she monitored those temperatures every day.
*Cook H stated there were no cleaning schedules and that the dietary staff worked together to keep the kitchen clean.

4. Observation on 2/17/26 at 4:42 p.m. of the Mechanical Room across from the kitchen revealed:
*A large rolling cart for the canned food that was covered with a large cloth, and a small cart that contained more than 20 cans of food and small bags of potato chips.
*There were electrical supplies, water heaters, two bottles of eye wash saline, loose batteries, lightbulbs in a box, a spray can of air freshener, a bucket with dirty rags, and a watering can on the floor.
*The floor of that room was dirty, had cracked floor tiles, missing floor tiles, contained two scrub brushes near the floor drain, and a Guardian Pest Solutions trap.
*There was no thermometer in the room for staff members to monitor the temperature of the room where the food items were stored.

5. Observation and interview on 2/18/26 at 10:17 a.m. with dining services director (DSD) C of the kitchen and food storage areas revealed:
*He had worked at the facility for about one month. He received one day of in-person training and had completed the required new employee training online.
*He thought the main kitchen dishwasher was a high-temperature dish machine, but was unsure what temperature the dishwasher needed to reach to sanitize the dishes. They did not record the temperatures of the dishwasher to support they were monitoring them.

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*He was developing logs to monitor and track kitchen cleaning, refrigerator, freezer, and food temperatures because those logs were not used when he was hired, but he thought they needed to be used.
*He expected the food and dishwasher temperatures, and the sanitizer level of the sani-bucket to be monitored with each meal.
*He expected all of the refrigerator and freezer temperatures to be monitored with each shift to ensure they were in and acceptable range.
*He was aware that the kitchen refrigerator temperature had been inconsistent. He confirmed the current temperature inside the refrigerator was 45°F. He expected the refrigerator to maintain 41°F or lower to prevent the food items from spoiling. He submitted an online work order on 2/3/26 regarding the refrigerator temperatures, but it had not been addressed.
*He expected routine kitchen cleaning to be completed with each meal service, the kitchen to be swept, moped and cleaned at the end of each day, and a deep cleaning was expected each weekend.
*He confirmed that the dishwasher, floors, stove, and footstool in the main kitchen were not clean.
*He was unaware that the thermometer probe wipes in the main kitchen had expired.
*He confirmed there were boxes of food on the floor inside the cabinet in the dining room.
*He confirmed that the open containers of milk and juice in the dining room refrigerator made from a concentrate should have been dated when they were opened.
*He did not monitor the temperature in the Mechanical Room, where canned foods were stored.
*He stated that there was no separate refrigerator for staff food, and staff food had been stored in the kitchen and pantry refrigerators. He expected

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all food items to be labeled and dated.
*He expected leftover food items to be labeled with the food item, the date they were opened, the use-by date, and discarded after the use-by date.

6. On 2/18/26 at 11:36 p.m., executive director A was requested to provide documentation on kitchen cleaning, refrigerator, freezer, dishwasher, food temperature monitoring, and monitoring of the kitchen chemical sanitizer bucket levels for the period of September 2025 through February 2026. No documentation was provided for that time frame before the survey exit.

7. Interview on 2/19/26 at 2:05 p.m. with executive director A revealed:
*She was aware that the dietary staff had not been completing the required temperature monitoring logs for the dishwasher sanitizing or food storage.
*There was no employee refrigerator, and she was aware that at times, staff used the kitchen refrigerator to store their personal lunch items.
*DSD C was hired in January 2026 and was working to resolve the "issues" within the dietary department.

8. Interview on 2/19/26 at 2:30 p.m. with director of nursing B revealed:
*Her office was located in the memory care unit and was across the hall from the kitchen.
*She was unsure who was responsible for monitoring and cleaning the refrigerator in the memory care kitchen, but thought it was likely the responsibility of the dietary department.

9. Review of the provider's July 2024 Dining Services Policy and Procedure Manual revealed:

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*"The dining services Director ... responsibilities include overseeing the dining room, ordering, preparation and serving of meals, and cleaning and sanitation of the kitchen and dining areas. The dining service Director/supervisor ... delegates or personally completes the functions necessary to maintain company standards. The dining service director also .... Operates a clean kitchen and dining room, Assures safe and sanitary food handling practices..."

10. Review of the provider's July 2024 Using Leftovers policy revealed:
*"It is the policy of this community that all leftovers are handled properly."
*"Cover and label all food with the contents and the date of preparation."
*"Freeze all potentially hazardous foods within 24 hours or refrigerate and use them within 3 [three] days."

11. Review of the provider's July 2024 General Cleaning Instructions (Kitchen) policy revealed:
*"Proper Cleaning and sanitizing are one of the most important responsibilities of any kitchen employee."
*"Assign cleaning tasks, post a cleaning schedule, and make sure it is signed off by employees."
*"Keep the kitchen neat, clean, common, orderly, and uncluttered at all times. Make sure storage areas are well organized ..."
*"Keep the dish machine and dishwashing area clean and free of stains and chemical or hard water buildup. Keep the shelves and backsplash organized and clean."

12. Review of the provider's July 2024 Equipment Specific Cleaning Instructions policy revealed:
*"Dishwashing Procedures ... Cleaning

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S 105	Continued From page 18 dishwashing equipment ...gives you clean, sanitary dishes." *"Temperatures in sanitizer must be checked three times daily." *"Floor Daily Steps ...Clean kitchen and store room floors with detergent and water." 13. Review of the provider's July 2024 Food Safety Procedure policy revealed: *"On each package that is removed from its original container, right when the item was received, or when it was stored after preparation." *"Do not store any items on the floor." *"Dry storage temperatures should be 50-[to]70°F..." *"Cold food storage temperatures should be 32-41°F. Temperatures should be monitored and recorded 2 [two] times per day to assure food is stored at safe temperatures." 14. Review of the provider's July 2024 Food Storage Guide policy revealed a reference to "A complete Food Storage Guide can be found in the Appendix. (A-7). That Appendix was not provided before the survey exit.	S 105		
S 115	44:70:02:07 Handwashing Facilities Handwashing facilities consisting of hot and cold running water dispensed through a mixing faucet controlled with blade handles or other hands-free controls, a towel dispenser with single-service towels or a hand-drying device, and hand cleanser must be located in dietary areas, utility rooms, staff stations, physical therapy rooms, laundry rooms, and all toilet rooms. A handwashing facility must be provided in each resident room or in a bath or toilet room connected directly to the room. If existing faucets	S 115	ED will work with corporate office to supply paper towel and soap dispensers for each AL unit. No updates to policies are required.	4/5/26

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and controls are replaced or changed, they must be replaced with mixing faucets controlled with blade handles or other hands-free controls.

This Administrative Rule of South Dakota is not met as evidenced by:
Based on observation, interview, and policy review, the provider failed to ensure that the handwashing sinks located in resident rooms were equipped with hand cleaner and a towel dispenser with single-service towels or a hand drying device in twenty two of twenty two occupied resident rooms in the assisted living wing.

Findings Include:

1. Observation and interview on 2/18/26 at 11:42 a.m. with resident 1 in her room revealed:
*She provided her own paper towels, cloth towels, and soap for hand washing.
*Staff members did not wash their hands in her room before or after they assisted her because they wore gloves.

2. Observation and interview on 2/18/26 at 11:48 a.m. with resident 7 in her room revealed:
*She provided her own cloth towels and soap for hand washing.
*She thought that staff members washed their hands when they were in her room, assisting her, but was unsure how they dried their hands because there were no disposable hand towels.
*She stated she did not think staff members used her cloth hand towel to dry their hands.

3. Interview on 2/18/26 at 11:52 a.m. with certified medication assistant (CMA) F revealed:
*He never used the residents' sinks in their rooms

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to wash his hands before or after he assisted them with their medications or personal care.
*Residents provided their own soap and hand towels. He wore gloves and used hand sanitizer when he assisted residents with their care.
*If he needed to wash his hands, he would use the public restroom located in the lobby to wash his hands.

4. Observation and interview on 2/18/26 at 2:32 p.m. with CMA M revealed:
*She typically worked in the facility's memory care wing, where a soap dispenser and single-use paper towels were available. She thought that each resident room sink in the assisted living should contain a soap dispenser and single-use paper towels so staff members have access to wash and dry their hands.
*She confirmed that resident 5's room in the assisted living wing did not contain facility-provided soap or paper towels.
*She confirmed that resident 8's room in the assisted living wing did not contain facility-provided soap or paper towels.
*She wore gloves and used hand sanitizer when she provided resident care.
*The only sink available with facility-provided soap and paper towels that she knew of in the assisted living wing was in the kitchen and in the single public restroom in the lobby.

5. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed:
*She confirmed that the resident rooms in the assisted living wing did not contain facility -provided soap or single-use towels. The resident rooms in the memory care wing were equipped with soap dispensers and single-use paper towels.
*She was unsure why the resident rooms in the

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assisted living wing did not contain soap dispensers and single-use paper towels.
*She expected staff members to wash their hands after providing resident care, even if they wore gloves.
*She thought the only sink available to staff members for washing their hands was in the public restroom.

6. Interview on 2/19/26 at 2:10 p.m. with executive director A revealed:
*She was aware that resident rooms in the assisted living wing did not contain facility -provided soap or single-use towels.
*Residents were expected to provide their own hand washing soap, and most residents used cloth hand towels.
*She recently purchased hand soap and paper towels for resident 1 when she was admitted because resident 1 did not bring hand soap or towels with her when she was admitted to the facility.
*She was unaware that the handwashing sinks located in resident rooms should have been equipped with hand cleaner and a towel dispenser with single-service towels or a hand drying device

7. Review of the provider's February 2012 Hand Washing Guide revealed:
*Hand washing should be done before and after caring for a resident, before and after handling food or medication, after handling a resident's belongings, after working with anything soiled, before putting on gloves, and after removing gloves.
*"Apply soap ... working it into a lather ... rinse hands ...dry hands and wrists with a clean paper towel."

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S 115	Continued From page 22 8. Review of the provider's November 2022 Hand Hygiene policy revealed: *"Hand hygiene should be done: ...Before and after caring for residents ...after working with anything soiled, before putting on gloves, after removing gloves."	S 115		
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to ensure that a facility-wide infection prevention and control program was in place and assigned to a staff member to implement and oversee it. Findings include: 1. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed: *She was not assigned to implement or oversee an infection control program at the facility and was unaware whether any person at the facility was assigned to that task. *She was unsure where to find policies related to	S 130	The Clinical Services Director (CSD) will serve as the designated Infection Preventionist and will oversee the infection control program. In the absence of the CSD, a trained designee (RN) will assume responsibility. The Infection Preventionist (CSD) will be responsible for ensuring all required infection control education is completed. Education will include standard precautions, hand hygiene, PPE use, and outbreak management. Completion will be tracked and maintained by the CSD and/or designee.All infection prevention and control policies were reviewed and updated to reflect current best practices and regulatory requirements with no revisions needed The infection control program includes ongoing monitoring and audits to ensure compliance: Hand hygiene compliance Proper PPE use, Environmental cleanliness, Infection tracking and trending The Infection Preventionist (CSD) or designee will complete audits weekly for 4 weeks, then monthly thereafter.	4/10/26

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S 130	Continued From page 23 the facility's infection prevention and control program. 2. Interview on 2/19/26 at 2:10 p.m. with executive director A revealed: *She was unsure if any staff member at the facility was assigned to implement or oversee an infection control program at the facility. *She expected DON B to have the policies for all areas related to resident care and nursing services, including infection control and prevention. 3. Review of the providers' DON job description revealed it did not address the facility's infection prevention and control program or the assignment of that role or responsibilities.	S 130		
S 131	44:70:02:09 Infection Prevention And Control The facility shall have written procedures that govern the use of aseptic techniques and procedures in all areas of the facility. Each facility shall develop written policies and procedures for the handling and storage of potentially hazardous substances. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to have written policies and procedures to govern the use of aseptic techniques and procedures for all areas of the facility available to the staff. Findings include: 1. Interview on 2/19/26 at 12:55 p.m. with director	S 131	Training will be assigned and completed by all staff on a yearly basis and cover "Proper Hand Hygiene and Glove Usage". Policies on infection control were reviewed and no changes were needed. Community RN/LPN will perform Proper Hand Hygiene audit on 4 individuals per month for 3 months, and 2 individuals per month for 3 months and monthly thereafter for 6 months. This will be reported to the monthly QA committee by the Community RN.	4/15/26

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S 131	Continued From page 24 of nursing (DON) B revealed: *She was not assigned to implement or oversee an infection control program at the facility and was unaware whether any person at the facility was assigned to that task. *She was unsure where to find policies related to the facility's infection prevention and control program. 2. Interview on 2/19/26 at 2:10 p.m. with executive director A revealed: *She was unsure if any staff member at the facility was assigned to implement or oversee an infection control program at the facility. *She expected DON B to have the policies for all areas related to resident care and nursing services, including infection control and prevention. 3. On 2/19/26 at 2:30 p.m. executive director A was requested to provide policies related to the facility's infection prevention and control program and the use of aseptic techniques and procedures for all areas of the facility. Those policies were unavailable and not provided before the survey exit.	S 131		
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility.	S 165		

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S 165	Continued From page 25 This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to operate the facility in a manner to avoid the potential for injury or danger to occupants regarding: *A soup warmer that overheated, and one of one resident (10) sustained a hot liquid burn to her leg. *One of one main door exit in the assisted living wing was not locked, alarmed, or monitored at all times. Findings include: 1. Review of the 4/22/25 SD DOH FRI revealed: *On 4/3/25 at 11:30 a.m., resident 10 sustained a "hot liquid burn to the medial aspect [middle] of her left thigh" when she reached for her soup and knocked the bowl of soup into her lap. *The soup temperature was 171 degrees Fahrenheit (F). *"Wound treatments and skin monitoring continued through 4/21/25." *"Staff will assist [resident 1] with locating her food due to her visual impairment to help prevent future accidents." *Further documentation was requested at the time of the report and was not provided. 2. On 2/18/26 at 1:36 p.m., a request was made to executive director A for all documentation related to the incident on 4/3/25 related to resident 10's hot liquid burn incident. 3. Interview on 2/19/26 at 9:12 a.m. with dining services director (DSD) C revealed: *He started working at the facility about one	S 165	All dietary staff received education on proper food storage and handling, including food temperatures. Policies on proper food storage and handling were reviewed with recommendation to update policy to include recommended serving temperature. The cooks are responsible for completing temperature logs daily including food temperatures. DSD will review temp logs weekly for compliance. DSD will audit food labeling, storage and cleaning weekly x 1 month and then quarterly for 6 months. DSD will present findings at the monthly QI meeting. Resident dignity policy will be updated to include the following language "to provide adequate supervision and assistance" A review of all AL residents with a SLUMS score below 20 will have a re-evaluation of their elopement risk if has not been completed in the previous 30 days. Care plan will be updated with interventions as needed for those at risk. Resident 3 will be transferred to the secured MC by 4/3/26	4/10/26 4/10/26

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S 165	Continued From page 26 month ago. *He had not been aware that resident 10 had sustained a hot liquid injury from a bowl of soup in April 2025. *Since he was hired a month ago, he discovered that the soup warmer had been overheating, and it had been discarded, and a new soup warmer was in use currently. *He thought that 171F was too hot a temperature for soup to be served to residents and expected the soup to be about 145 F when it was served for residents to eat. 4. Review of resident 10's electronic medical record (EMR) revealed: *She was admitted to the facility on 1/2/25. *Her 2/4/25 service plan indicated she was independent with eating, drinking, mobility, and managing her environment. *There was no documentation on 4/3/25 regarding resident 10 sustaining a burn, whether vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) had been taken, or whether an initial assessment of the injury had been completed. There was no documentation on whether the resident's family or provider had been notified of the injury. *A 4/4/25 nursing progress note indicated "Medical Doctor Appointment Referral: Reason: second degree burn to left thigh." Resident 10 returned from the appointment with a dressing order to be completed daily and a referral to the wound clinic. *A 4/5/25 nursing progress note indicated: -On 4/4/25, resident 10 "sustained a hot liquid burn to the medial aspect of her left thigh," was seen by her primary care physician (PCP) on 4/5/26, and the PCP "assessed and dressed the wound."	S 165	The main entrance is montiored and alarmed by personnel between the hours of 8am to 5pm Mon-Fri. The front door is alarmed when personnel is not present. The door is locked from 10p to 5:30am. The door has an egress lock feature with a 15 second emergency bar to exit. The assisted living resident handbook will be update to include with this information.	4/10/26

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-On 4/5/25 director of nursing (DON) arrived to change the dressing. "The wound was approximately 10cm [centimeters] X {by] 10cm," "bright pink," and there was a 3cm fluid-filled blister and several smaller blisters.
*There was no documentation that an investigation was completed.
*Resident 10 attended at least six wound clinic appointments regarding her hot liquid burn, and the burn was noted as healed on 6/20/25.

5. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed:
*She did not work on 4/3/25 when resident 10 had sustained a hot liquid burn to her leg, but was aware that the burn had been caused by a bowl of soup. She saw the burn approximately two days after the incident and described the burn as a large burn with several blisters.
*She expected that resident 10's burn would have been documented in her EMR when it occurred, reported to the SD DOH within 24 hours of the incident, and that an investigation would have occurred related to how resident 10 had sustained that burn.
*DON B was unsure if an investigation into resident 10's hot liquid burn had occurred and stated she provided all the records related to resident 10's hot liquid burn that she could find, but had not found an investigation into how the burn had occurred or what, if any, interventions had been put in place after that incident occurred to prevent it from happening again.

6. Interview on 2/19/26 at 2:10 p.m. with executive director A revealed:
*Resident 10 was discharged from the facility before she was hired as the executive director at the facility.
*She was unaware that resident 10 had sustained

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a hot liquid injury from a bowl of soup, or whether an investigation into that incident occurred.
*She was aware that DSD C had reported in February 2026 that the soup warmer was overheating, and a new soup warmer had been purchased at that time.

7. Review of the provider's July 2024 Food Temperatures policy revealed:
*"All hot food must be held at 135 degrees or above ..."
*"Keep food covered and stir frequently to maintain an even temperature ..."
"Monitor temperatures."
*There was no documentation of what temperature food should be served to residents.

8. Review of the 2013 American Burn Association Scald Injury Prevention guide revealed:
*"Older adults ... have thinner skin so hot liquids cause deeper burns with even brief exposure."
*At 155F it takes one second for a third-degree burn to occur.

9. Review of the provider's May 2023 Resident Dignity policy revealed:
*" Maintain a system to ensure a pleasant, relaxing dining environment, similar to that in a fine restaurant. Consider the following ... Provide adequate supervision and assistance."

10. Observation on 2/17/26 at 12:32 p.m. of the main entrance and exit doors of the assisted living area revealed:
*The main entrance to the assisted living was located in the lobby near the business office and outside of the residents' dining room.
*Executive director A's office door was closed. The business office door was open, and two staff members were engaged in a task in that office.

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*Residents were walking in the lobby outside of the dining room.
*The doors were unlocked, unalarmed, unattended, and exited to the parking lot. A doorbell chimed briefly when they were opened.
*There was a keypad on the wall next to the door with a green light indicating that the doors were unlocked.

11. Observation on 2/17/26 at 5:45 p.m. of the main entrance and exit doors of the assisted living area revealed:
*The business office and executive director A's doors were closed, and they had left for the day.
*Residents were leaving the dining room and walking into the lobby and down the hallways.
*There were no staff members present in the lobby near the main entrance and exit doors.
*The main entrance and exit doors were unlocked, unalarmed, and unattended by a staff member.

12. Review of the provider's 7/1/25 assisted living license revealed they had the additional service license for the care of cognitively impaired residents.

13. Interview on 2/18/26 at 9:45 a.m. with director of nursing (DON) B revealed:
*There were a few residents with cognitive impairment who lived in the assisted living wing.
*The main entrance doors to the assisted living near the dining room remained open and unalarmed daily between 5:30 a.m. and 10:30 p.m., and those doors were not monitored by a staff member when they were unlocked.
*Resident 3, who resided in the assisted living wing, was on one-hour safety checks because she had a recent decline in her cognition, liked to walk outside when the weather was nice, and

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they were unsure if she might try to exit the facility through the front doors.

14. Observation and interview on 2/18/26 at 4:10 p.m. with resident 3 revealed:
*Resident 3 exited the dining room and walked to her room in the assisted living wing.
*She motioned to the surveyor to come into her room. She was holding her remote control and cell phone and asked what she should do with them.
*She stated she did not know what to do.
*When prompted to go see if dinner was ready, she took the surveyor's hand and walked to the dining room, where a staff member assisted her to find her chair.

15. Interview on 2/18/26 at 4:14 p.m. with certified medication aide (CMA) M revealed:
*CMA M observed resident 3 return to the dining room and stated that resident 3 had been "wandering" frequently today.
*Resident 3 liked to walk in the hallway and outdoors with resident 4.
*She felt resident 3 was more confused and worried that resident 3 might try to go outdoors when the weather was warmer without staff knowing.
*CMA M did not think that resident 3 had ever gone outside the facility without a staff member's awareness.

16. Review of resident 3's electronic medical record revealed:
*She was admitted to the facility on 2/10/25.
*Her diagnoses included Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions) and anxiety (anticipation of future danger or misfortune with feelings of distress

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and/or sadness and symptoms such as restlessness or irritability) disorder.
*Her 2/12/26 Saint Louis University Mental Status (SLUMS) Examination score was 8, which indicated her score fell within the "dementia" category and she would need further testing to determine appropriate treatment.
*On 2/11/25, resident 3 was placed on every one-hour staff safety checks to "monitor [the] resident closely to ensure that she does not leave the building on her own."

17. On 2/18/26 at 4:08 p.m. executive director A was requested to provide a door alarm policy and a policy related to the care of residents with cognitive impairment, and those policies were not provided before the survey exit.

18. Interview on 2/19/26 at 2:10 p.m. with executive director A revealed:
*She confirmed that the facility's main entrance and exit doors to the assisted living near the dining room remained open and unalarmed daily between 5:30 a.m. and 10:30 p.m., and those doors were not monitored by a staff member when they were unlocked.
*She confirmed the facility was licensed for the care of cognitively impaired residents,
and that residents with cognitive impairment, including resident 3, lived in the assisted living wing.
*She confirmed that with the unlocked, unalarmed, and unmonitored doors, there was a safety risk of residents leaving without staff knowledge.

19. Interview on 2/19/26 at 3:27 p.m. with DON B regarding resident 3 revealed:
*Resident 3 had experienced a cognitive decline in the past month, had been more confused, and

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S 165	Continued From page 32 had demonstrated increased wandering. She was seen by her physician to rule out a medical cause for the increased confusion. *On 2/11/25, resident 3 was placed on every one-hour staff safety checks because she was waiting at the front door for resident 4 to go outside to water the plants and had asked if resident 4 had left without her. *Resident 3 had not left the facility unsupervised, but DON B and other staff members were worried that resident 3 would exit the facility when staff were unaware, because the main entrance and exit doors to the assisted living facility remained open and unalarmed daily between 5:30 a.m. and 10:30 p.m., and those doors were not monitored by a staff member at all times. 20. Review of the provider's May 2021 Assisted Living Resident Handbook revealed: *"Security ... For your safety and security, the outside entrance door to the community is locked from 10:30 PM till 5:30 am."	S 165		
S 275	44:70:04:01 Governing Board Each facility operated by a limited liability partnership, a corporation, or a political subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this chapter pertaining to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the governing body failed to	S 275	Edgewood Senior Living organizational chart was provided. Members of the QI teams include the ED, BOD, CSD, DSD, RN/LPN. Meetings are held monthly and reports are uploaded to a company program (TELS). Regional and corporate office are able to review notes.	2/19/26

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S 275	Continued From page 33 ensure the facility was administered in a manner that ensured the daily overall management, resident care, and resident safety were in compliance with the Administrative Rules of South Dakota 44:70 Assisted Living Centers regulations. Areas included: *Investigation and timely notification of a critical incident to the South Dakota Department of Health. *Ensuring the main door in the assisted living wing had been locked, alarmed, or monitored at all times. *Annual required training had been completed by all employees. *Ensuring housekeeping policies were available to staff and that chemicals utilized for cleaning were stored in a safe and secure manner. *Adequate handwashing supplies, including soap and single-use towels, were available in resident rooms for staff to use when providing resident care. *Lack of policies and procedures related to infection control and the implementation of a program to identify, prevent, and control the spread of communicable disease. *Annual facility tuberculosis (TB) risk assessment not completed, and the two-step TB screening not completed within 21 days for two residents and one staff member. *Care plans had been reviewed and updated to reflect the current needs for six sampled residents. *Proper documentation of the disposition of medications for two residents upon discharge. *Resident confidentiality and privacy was maintained with confidential information displayed on two resident computers. *A dietary department that: -Maintained the storage of food in an environment that prevented the potential for food-borne illness.	S 275		

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S 275	Continued From page 34 -Reviewed the dietary policies on an annual basis. -Established and maintained an emergency three-day food supply. -Had a dietary manual available. Findings include: 1. Interview on 2/17/26 at 12:30 p.m. and again on 2/19/26 at 3:10 p.m. with executive director A revealed: *A copy of the current members of the governing board was requested upon entry to the facility. *The facility provided an undated "Edgewood Healthcare Senior Living - Division Organization Chart". -The above form differed from the governing board information submitted with their annual license renewal in May 2025. *The governing body was not involved in the daily operations of the facility. Concerns were identified related to several areas of facility operations. Refer to S030, S080, S095, S096, S105, S115, S130, S131, S165, S295, S305, S330, S331, S405, S450, S465, S474, S489, S603, S685, S820, and S850.	S 275		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator.	S 280	ED will complete the Administrator training course within 6 months of hire The RVP provides oversight and training to ED as needed on a continual basis and ensures reporting has been completed.	04/15/26

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S 280	Continued From page 35 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the administrator failed to ensure the facility was managed in a manner to ensure: *Investigation and timely notification of a critical incident to the South Dakota Department of Health. *The main door in the assisted living wing had been locked, alarmed, or monitored at all times. *Annual required training had been completed by all employees. *Housekeeping policies were available to staff and that chemicals utilized for cleaning were stored in a safe and secure manner. *Adequate handwashing supplies including soap and single-use towels were available in resident rooms for staff to use when providing resident care. *Infection control policies and procedures were available, and an infection control program had been implemented to identify, prevent, and control the spread of communicable disease. *An annual facility tuberculosis (TB) risk assessment was completed, and the two-step TB screening was completed within 21 days for two residents and one staff member. *Care plans had been reviewed and updated to reflect the current needs for six sampled residents. *Proper documentation of the disposition of medications for two residents upon discharge. *Resident confidentiality and privacy was maintained with confidential resident information was displayed on two facility computers. *A dietary department that: -Maintained the storage of food in an environment	S 280		

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that prevented the potential for food-borne illness.
-Reviewed the dietary policies on an annual basis.
-Established and maintained an emergency three-day food supply.
-Had a dietary manual available.

Findings include:

1. Interview on 2/19/26 at 3:10 p.m. with executive director (ED) A revealed:
*She had been employed by the facility since August 2025.
*She was in the process of completing the department approved assisted living administrator course but had not completed it yet.
*Regional Vice-President S was the administrator on record and provided her oversight.
-ED A did not identify how often she met with Regional Vice-President S or the guidance that was provided.

Concerns were identified related to several areas of facility operations. Refer to S030, S080, S095, S096, S105, S115, S130, S131, S165, S295, S305, S330, S331, S405, S450, S465, S474, S489, S603, S685, S820, and S850.

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44:70:04:04 Personnel Training

The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually.

This Administrative Rule of South Dakota is not met as evidenced by:

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S 295	Continued From page 37 Based on personnel file review and interview, the provider failed to ensure one of seven sampled employees (D) had completed all the required annual training topics. Findings include: 1. Review of employee D's personnel file revealed: *She was hired on 1/24/05. *She had not completed the required annual training in 2025 for the following topics: -Emergency procedures and preparedness. -Resident rights. -Confidentiality. -Abuse, neglect, and misappropriation of resident property and funds. 2. Interview on 2/19/26 at 1:40 p.m. with business office manager O revealed: *The required employee trainings were assigned through the [name of company] online training module. *There was no documentation to support that employee D had completed the topics identified above in 2025. 3. Interview on 2/19/26 at 3:10 p.m. with executive director A confirmed that employee D had not completed the above required topics as assigned.	S 295	All new hires will be enrolled in the new live orientation hire through Relias. Topics covered in this session are the required training of Edgewood and OSHA All state specific mandated training will be covered in a biweekly orientation in the community for all new hires. Policies on new hire orientation were reviewed. No changes or revisions needed. Ongoing education will be done following our annual training calendar along with our Relias online training program, and in person training during scheduled staff meetings. ED and Nurse will audit all new hire charts monthly for 6 months to ensure compliance on orientation. Audit findings will be reviewed at monthly QA meetings for 6 months. Employee D will complete training topics required. Policies on new hire orientation were reviewed. No changes or revisions needed. BOD will audit/monitor that Community RN or LPN completes Health screening evaluation within 14 days of hire every two weeks for two months. BOD will then monitor that Community RN or LPN completes Health Screening Evaluation within 14 days of hire monthly. During monthly quality assurance meetings, these audits will be reviewed and will be adjusted appropriately if need be.	4/10/26
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before	S 305		

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S 305	Continued From page 38 assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel record review and interview, the provider failed to ensure two of seven sampled employees (P and Q) were evaluated by a licensed health professional within 14 days of hire. Findings include: 1. Review of the employee's personnel records revealed the following: *Employee P was hired on 10/17/25. *Employee Q was hired on 8/27/25. *The above employees: -Had no health history screening forms completed. -Were not evaluated by a licensed health professional according to the requirement. 2. Interview on 2/19/26 at 1:40 p.m. with business office manager (BOM) O revealed: *She was responsible for completing the onboarding paperwork and training with new employees. *The health screening form and tuberculin screening forms were provided to the nursing staff to complete. *The completed forms were to be placed in the employee's personnel file. -The health screening forms for employees P and Q had not been returned to her to place in the personnel files. 3. Interview on 2/19/26 at 2:30 p.m. with director of nursing B revealed:	S 305	Education will be provided by ED to the Clinical Services Director and clinical team. Policies were reviewed and no changes are required. BOD will audit health screening completion and will report to QI monthly until 6/30/26.	4/10/26

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S 305	Continued From page 39 *There was no documentation to support that employees P and Q had a health screening form completed. *She acknowledged that the health screening form was to be completed by the nursing staff and returned to the employee's personnel file. 4. On 2/19/26 at 1:10 p.m., BOM O was requested to provide an employee onboarding policy, and she confirmed at 1:40 p.m. that the facility did not have a policy for employee onboarding.	S 305		
S 330	44:70:04:10 Tuberculin Screening... Requirements Each facility shall develop criteria to screen healthcare personnel and residents for Mycobacterium tuberculosis (TB) based on the Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. Each facility shall establish policies and procedures for conducting TB risk assessment that include the key components of responsibility, surveillance, and containment. The frequency of repeat screening depends upon annual facility risk assessment results. Any resident identified as asymptomatic upon admission as short stay or anticipated stay of thirty days or less is not required to have a tuberculin skin test or a TB blood assay test. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, the provider failed to ensure an annual tuberculosis (TB) risk assessment had been completed by the facility staff.	S 330	The Executive Director is responsible for completing the TB risk assessment for all residents and staff, in accordance with SD assisted living regulations. The current 2026 TB risk assessments will be completed by March 31st. Policies regarding TB risk assessments were reviewed and no revisions needed. The results of the TB risk assessment will be shared with Quality Assurance (QA) for review and monitoring and the requirement tracker completed by the ED in Relias (online education system). This is completed annually by the end of 3rd quarter by the ED on the Corporate Education compliance.	3/31/26

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S 330	Continued From page 40 Findings include: 1. Interviews on 2/19/26 at 2:30 p.m. with director of nursing B and 3:10 p.m. with executive director (ED) A regarding the facility's annual TB risk assessment revealed: *The document was to be completed in March of each year by the director of nursing. *They were unable to locate documentation to identify when the risk assessment had last been completed. *The previous director of nursing who had been responsible for ensuring the previous assessments were completed was no longer employed with the facility. -The current director of nursing was hired on 2/7/25. 2. On 2/19/26 at 8:00 a.m. ED A was requested to provide a TB risk assessment policy, and a policy was not provided before the survey exit. .	S 330		
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of	S 331	CSD, BOD, and ED will audit personnel files and resident's records to identify any other individuals missing timely TB testing. All new hired employees are scheduled TB testing with new hire orientation. A calendar reminder has been added to the nurse in charge of clinical orientation. That nurse is then responsible to ensure that 2 steps has been completed within 21 days of hire. Resident TB testing will be placed on EMR to notify nurses of TB testing due dates. Regional nurse director educated nurses on SD requirements of TB testing. Policies on Tuberculin Testing were reviewed. No changes or revisions needed. BOD or designee will conduct monthly audits of new employees and resident records for 6 months. BOD will present audit findings in monthly QAPI meetings.	4/5/26

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admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;

This Administrative Rule of South Dakota is not met as evidenced by:
Based on record review, interview, and policy review, the provider failed to ensure that a two-step tuberculin skin test was documented for two of three sampled residents (1 and 2) who resided in the assisted living wing and one of seven sampled employees (A) within 21 days of their admission to the facility or their date of hire.

Findings include:

1. Review of resident 1's care record revealed:
*She was admitted on 8/25/25.
*There was no documentation of a completed

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two-step tuberculin skin test within the twelve months before her admission or within 21 days of her admission to the facility.

2. Review of resident 2's care record revealed:
*He was admitted on 5/16/25.
*There was no documentation of a completed two-step tuberculin skin test within the twelve months before his admission or within 21 days of his admission to the facility.

3. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed she had been unable to find documentation that resident 1 or resident 2 had a two-step tuberculin skin test completed within the twelve months before their admission or within 21 days of their admission to the facility.

4. Review of executive director (ED) A's personnel file revealed:
*She had been hired on 8/18/25.
*The consent for TB testing form was signed by ED A on 2/9/26.
*Her first dose was administered on 2/9/26 and read on 2/11/26.
*The second dose had been administered on 2/16/26 and had not been read by the conclusion of the survey.

5. Interview on 2/19/26 at 2:30 p.m. with DON B revealed:
*The nurses were responsible for the completion of the TB screenings for new residents and staff within 21 days of hire or admission.
*She acknowledged that ED A's TB screening fell outside of the 21 days after she was hired.

6. Review of the provider's February 2026 TB Screening South Dakota - Employee and

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S 331	Continued From page 43 Resident policy revealed: *"Each healthcare employee or resident shall receive an initial TB risk assessment that is documented and the two-step method of tuberculin test within 21 days of employment or admission. This test will be administered and read by a licensed nurse. Any two documented tuberculin skin tests completed within 12 months prior to the date of admission or employment are considered two-step".	S 331		
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure the written service plan addressed the current care needs for six of six sampled residents (1, 2, 10, 12, 13, and 14). Findings include: 1. Interview on 2/17/26 at 1:44 p.m. with resident 1 in her room revealed: *She was diabetic (a condition involving disruptions in how the body regulates blood sugar) and completed her own insulin injections each week. Her insulin was stored in her refrigerator.	S 405	A standardized process has been implemented to ensure all care plans/service plans are: Completed upon admission, 30 days and updated with any significant change in condition Resident care plans are reviewed at a minimum of monthly in the Service Level Meeting that occurs weekly. The Community RN and LPN will be responsible for updating the resident evaluation and care plan to ensure that the resident needs are met when changes occur. RND reviewed Community RN and LPN care plan requirements, including timeliness, accuracy, and documentation standards. Policies on care planning and service plans were reviewed. No changes or revisions needed The ED will complete Weekly audits for 4 weeks Bi-weekly audits for 1 month of a random sample of 5 resident charts. Monthly audits thereafter for ongoing compliance for 6 months. These audits will be reviewed monthly at the QA meeting	4/10/26

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S 405	Continued From page 44 *She used a nebulizer (a device that converts liquid medication into an inhalable mist) to complete breathing treatments. She had two vials of the medication used in the nebulizer, but staff members usually brought the medication when it was due, or she requested it. 2. Review of resident 1's care record revealed: *She was admitted on 8/25/25. *A 12/5/25 physician's order for Ipratropium-Albuterol inhalation as-needed every six hours. *A 12/12/25 physician's order for Ozempic injections weekly starting on 12/29/25. *Her service plan did not include that she self-administered medications. 3. Review of resident 2's care record revealed: *He was admitted on 5/16/25. *A 9/13/25 physician's order for "CBD [Cannabidiol, a non-psychoactive compound derived from hemp] lotion to aching joints. May have at bedside." *His service plan did not include that he self-administered his CBD lotion. 4. Review of resident 10's care record revealed: *She was admitted to the facility on 1/2/25. *Medications listed as self-administered daily were Citrucel Powder and Psyllium Fiber ordered on 1/3/25. *Medications listed as self-administered as-needed were Antacid tablets and simethicone chewable tablets ordered on 1/2/25 and omeprazole ordered on 1/9/25. *Her service plan did not include that she self-administered medications. 5. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed:	S 405		

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S 405	Continued From page 45 *She was unaware that resident 1, 2, and 10's service plans did not include that they self-administered their medications. 6. Review of resident 12's care record revealed: *He was admitted on 9/3/21. *On 1/21/25, he was admitted to hospice services with a primary diagnosis of congestive heart failure. *His 11/25/25 service plan identified hospice in three areas: -"Support network....Relatives and Hospice Care Team." -"Case Management....on hospice." -"Other services needed....[agency name] Hospice". *His service plan did not include how hospice was integrated into his plan of care to ensure his needs were met. 7. Review of resident 13's care record revealed: *She was admitted on 4/17/23. *On 2/6/26, she had been prescribed albuterol 0.083% (inhaled medication to open the airways) by nebulizer (a device that converts liquid medication into an inhalable mist) three times a day. *Her service plan did not include that the self-administered the nebulizer medication. 8. Review of resident 14's care record revealed: *She was admitted on 4/18/23. *A review of her bathing log from 11/1/25 to 2/19/26 revealed her weekly shower had been marked as declined or refused at least nine times. *Her service plan did not address her frequent refusals of personal care or provide interventions to promote her compliance with the task of bathing.	S 405		

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S 405	Continued From page 46 9. Interview on 2/19/26 at 9:30 a.m. and again at 2:30 p.m. with DON B regarding resident service plans revealed: *She acknowledged that the hospice care that resident 12 received had not been integrated into his service plan. *The service plan for resident 13 did not address her ability to self-administer the nebulized medication. *Interventions were not provided in the service plan for resident 14's frequent refusals of care. *She agreed that the service plans for residents 12, 13, and 14 did not reflect each resident's current needs. *Resident service plans were updated by the facility nurse and done with each resident evaluation or if the resident had a change in their health status. 10. Review of the provider's February 2026 Service Planning/Care Planning and Coordination of Care policy revealed: *"As a basic health service tool, the Service Planning/Care Plan is used to identify resident care issues, how staff should monitor/observe for them, and interventions for each resident that staff can apply if necessary. Because it is the primary health record, other documentation about a resident's care should coordinate with and through the Service Planning/Care Plan." *"This document specifies particulate requirements for ...Self-administration of medications ... evaluations should be ongoing with the current reviewed, at least annually and with any significant change in condition."	S 405		
S 450	44:70:06:01 Dietetic Services	S 450		

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S 450	Continued From page 47 The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to prevent foodborne illness risks in one of one kitchen to: *Ensure proper hand hygiene, glove use, and temperature probe cleaning by one of one observed cook (D) during meal service preparation and serving. *Ensure the use of hair restraints and hand hygiene by three of three observed cooks (D, E, and J), one of one dietary services manager (C), and two of two certified medication aides (G and I). Findings include: 1. Observation on 2/17/26 at 1:22 p.m. of cook D in the main kitchen revealed: *She was preparing food. *She wore a black cap and had long hair pulled back in a ponytail. Her ponytail reached the middle of her back, and the hair on the sides of her face reached her chin. *She did not wear a hair net. 2. Observation and interview on 2/17/26 at 4:05 p.m., with cook D revealed: *She entered the kitchen carrying a thermometer and stated that she had taken the temperature of the soups in the dining rooms. She did not record those temperatures.	S 450	Education will be provided for glove, hairnet usage, handwashing and hygiene with all kitchen staff and any others helping in the kitchen or serving food. This will be a detailed meeting on proper hand-washing procedures, proper glove usage, the need for hair and beard nets and personal hygiene with clothing. Policies were reviewed and no revisions necessary. The DSD will do weekly audits for 1 month and quarterly for 6 months on handwashing, hairnet and glove useage. The DSD will review audit results at monthly QA meeting	4/10/26

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*She used a thermometer probe wipe to clean the thermometer and took the temperature of the black beans, used that same probe wipe to clean the thermometer, took the temperature of the corn and rice, and then used that same probe wipe to clean the thermometer again. She did not record those temperatures.
-The thermometer probe wipes she was using had an expiration date of 11/19/25.
*Without washing her hands, cook H put on a pair of gloves, opened a bag of shredded cheese, a package of tortillas, placed sheet protectors on two pans, opened the menu binder, touched her hair, placed the tortillas on the pan, and then placed cheese on the tortillas before placing them in the oven. With her gloved hands, she left the kitchen, opened the door and the refrigerator across the hall, placed the bag of cheese into the refrigerator, returned to the kitchen, and discarded those gloves.
*Without washing her hands, cook H put on a new pair of gloves, touched the rolling cart, the food thermometer, and the oven door to remove the pan of tortillas. With those gloved hands, she touched her glasses, stacked the tortillas, held the tortillas to cut them, and then placed them in the steam table.
*With those same gloved hands cook H checked the temperature of the fruit in the container on the counter. The temperature was 59.4°F. She placed the container of fruit in the refrigerator, then removed her gloves.
*Cook H washed her hands, put on a new pair of gloves, and with those gloved hands she touched the rolling food cart, the menu slips, the lids to the steam table, the plates, the utensils used to scoop beans and corn, and placed tortillas on 17 plates as they were served to the residents in the assisted living dining room.

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3. Observation on 2/17/26 at 4:28 p.m., in the main kitchen and dining room revealed:
*Certified medication aide (CMA) I entered the kitchen, walked past the steam table that contained the residents' dinner food items, and placed items on the counter near the dishwasher. She had long hair in a clip and did not wear a hair restraint.
*CMA G entered the kitchen to get a pair of gloves. The gloves were located on the shelf above the food preparation area that contained open bags of cheese and tortillas. Her hair was long and worn up. She did not wear a hair restraint.
*CMA I returned to the kitchen to get a pair of gloves.
*Without washing their hands or using hand sanitizer, CMA G and CMA I put on those gloves. They wore those gloves while they served residents their plates of food in the dining room.

4. Interview on 2/17/26 at 5:14 p.m. with CMA G and CMA I revealed:
*They wore gloves to serve resident meals in the dining room. If they touched anything other than the resident's plate, they would remove those gloves and change them right away.
*They had not been told whether they needed to wear a hair restraint when they went into the kitchen. They thought that since they were not preparing the food, they would not need to wear hair restraints.

5. Observation and interview on 2/18/26 at 10:17 a.m. with dining services director (DSD) C in the kitchen revealed:
*He was cooking on the stove, had a short beard, and hair. He wore gloves but did not wear a hair or beard restraint.
*He was unsure if he needed to wear a hair or

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beard restraint and thought there were just a couple of cooks with long hair who were required to wear a hair restraint. He expected cook D to wear a hair net with her cap because her hair was long.
*He expected staff members to wear gloves when they prepared and served resident meals. He expected staff members to change their gloves after touching raw meat or when they touched ready-to-eat food items.
*He expected cook D to use tongs when serving ready-to-eat foods like tortillas.
*He was unaware that the thermometer probe cleaning wipes had expired, but expected a clean, unexpired wipe would be used to clean the thermometer with each food item, and when the staff member was done taking those temperatures.

6. Observation on 2/18/26 at 2:10 p.m. with cook E in the main kitchen revealed she was preparing a dessert item, had long hair that she wore up, and did not wear a hair restraint.

7. Observation on 2/18/26 at 5:05 p.m. with cook E in the main kitchen revealed she was serving the residents' dinner meal. She did not wear a hair restraint.

8. Observation on 2/19/26 at 7:58 a.m. with cook J in the main kitchen revealed he was preparing breakfast, had short curly hair, and did not wear a hair restraint.

9. Interview on 2/19/26 at 2:05 p.m. with executive director A revealed DSD C was hired in January 2026 and was working to resolve the "issues" within the dietary department. He confirmed that the resident meal preparation and serving processes should have been done with

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proper hand hygiene, glove use, and hair restraints to prevent potential foodborne illness or contamination by staff members.

10. Review of the provider's July 2024 Meal Services policy revealed:
*"Enforce the dress code, include hair restraints and aprons as appropriate."
*"See that food temperatures are taken ..."
*Responsibilities of the Dining Services Manager/Supervisor included "supervise all areas of the kitchen and dining room."

11. Review of the provider's July 2024 Dietary Services Uniform and Personal Hygiene policy revealed:
*"Employees working in the Dining Services department must have their hair properly restrained."
*"Proper hand-washing procedures must be followed."
*"Gloves must be worn during food preparation."

12. Review of the provider's July 2024 Dietary Services Safety and Hygiene policy revealed:
*"Wash hands at appropriate times... Restrain hair under a hair net or cap ..."
*"Hand Washing... Everyone handling food must wash their hands before beginning work... handling raw meat, or touching unclean surfaces, including bussing of dishes. Proper hand washing procedures must be followed."
*"...Stress the importance of cleaning and preventing contamination of food."
*"Glove Use ... Single use gloves are designated for one task, after which they must be discarded. Single use gloves should never be used in place of hand washing..."
*"Wearing gloves does not replace proper hand washing procedures. Washing hands thoroughly

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S 450	Continued From page 52 before and after wearing or changing gloves to remove any bacteria buildup." *"Once the gloves come in contact with a contaminated surface or you change the type of food being handled, they must be discarded and replaced with clean gloves." "Any activity requiring hand washing should also require clean gloves." *"Tongs, spatulas, and other tools should be used whenever possible to pick up food, place garnishes on plates..."	S 450		
S 465	44:70:06:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned emergency menus for three days. Findings include: 1. Observation and interview on 2/17/26 at 4:22 p.m. with cook D in the kitchen revealed: *The facility's emergency menus were not located in the menu binder where she expected to find	S 465	Effective immediately, the DSD has made a new and updated version of the emergency plan menu with all recipes. By April 1, 2026, we will have all necessary items to fulfill the emergency menu. The items needed to fulfill this will be ordered through Sysco in accordance to the agreement plan Edgewood has with Sysco for our emergency food supply. This menu/recipe binder will be found and located in the kitchen and the kitchen staff are made aware of where it is located as well as where the food stock is located.	4/5/26

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S 465	Continued From page 53 them. She thought that the emergency menu was kept in dining services director (DSD) C's office and that DSD C would provide those menus when they were needed. *She was unaware of what food items were included in the emergency menu, but thought that there was enough food on-site to feed the residents if there was an emergency. 2. Interview and review of the emergency menu on 2/19/26 at 9:12 a.m. with DSD C revealed: *There was no on-site three-day emergency menu printed and available to the dietary staff in the facility, but he was able to print one from his computer. *He had been working on updating the provider's food supply, but was unsure if the food items in the emergency menu were available on-site at the facility. *He felt that there was enough food on-site to feed the 43 assisted living residents, but agreed that the cooks would not know which food to prepare if there was an emergency. *There was no system in place to monitor the three-day emergency food supply, and he did not know if there was enough of each required food group. 3. Interview on 2/19/26 at 2:10 p.m. with executive director A regarding the emergency menus and food supply revealed: *She was unaware that the planned three-day emergency menu approved by the RD was not available on-site. *DSD C was working on reviewing the menus and updating the food supply. *She expected DSD C to maintain a food supply to match the three-day emergency menu. 4. Review of the provider's July 2024 Dining	S 465		

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S 465	Continued From page 54 Services Policies and Procedures Manual revealed that those policies and procedures did not address the provider's emergency menus or food supply.	S 465		
S 474	44:70:06:08 Written Dietetic Policies The facility shall have written policies and procedures that govern all dietetic activities. The policies and procedures must include food handling procedures, length of duration for leftovers, and opened packages of commercially prepared food in accordance with chapter 44:02:07. The facility shall review the policies and procedures yearly and revise as necessary. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure dietetic policies were reviewed yearly and revised as necessary in one of one kitchen. Findings include: 1. Observation and interview on 2/17/26 at 4:22 p.m. with cook D in the kitchen revealed she was unable to locate a diet manual or the facility's dietetic policies in the kitchen. She thought that those items might be kept in dining services director (DSD) C's office. 2. Interview and review of the facility's dietetic policies on 2/19/26 at 9:12 a.m. with DSD C revealed: *The facility's dietetic policies were kept in his office on the memory care unit. Those policies were dated "July 2024".	S 474	Dietary staff will receive education on polices and where to locate them on the shared drive All current policies are located on our company shared drive. These are reviewed annually and as needed. A printed manual will be made available and stored in the kitchen for staff reference.	4/10/26

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S 474	Continued From page 55 *He was unaware that the facility's dietetic policies need to be reviewed yearly and revised as needed. 3. Interview on 2/19/26 at 2:10 p.m. with executive director A regarding the facility's dietetic policies revealed that she was unaware that the facility's dietetic policies needed to be reviewed yearly and revised as needed, and she was unsure if that should have been completed by their corporate office or at the facility.	S 474		
S 489	44:70:06:12 Dietary Manual A therapeutic diet manual with a description of all diets served in the facility must be readily available in the facility to healthcare personnel. The manual must have been updated within the last five years. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and the diet manual review, the provider failed to ensure a current diet manual (updated within the last five years) was available in the facility for staff use. Findings include: 1. Observation and interview on 2/17/26 at 4:22 p.m. with cook D in the kitchen revealed she was unable to locate a diet manual or the facility's dietary policies in the kitchen. She thought that those items might be kept in dining services director (DSD) C's office. 2. Interview and review of two diet manuals on 2/19/26 at 9:12 a.m. with DSD C revealed:	S 489	All current policies are located on our company shared drive. A printed manual will be made available and stored in the kitchen for staff reference.	4/10/26

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S 489	Continued From page 56 *The diet manuals were kept in his office on the memory care unit. One was dated 2007, and the other was dated 2011. *He was unaware that the diet manual needed to be updated within the last five years. 3. Interview on 2/19/26 at 2:10 p.m. with executive director A regarding a current diet manual revealed that she was unaware that the diet manuals were not current and should have been updated.	S 489		
S 652	44:70:07:06 Drug Disposal Medications controlled under SDCL chapter 34-20B may not be returned to the dispensing pharmacy or to an authorized reverse distributor company. Documentation of destruction or disposal of medications must be included in the resident's record. The documentation must include the method of disposition (destruction, disposal, or return to pharmacy); the medication name, strength, prescription number (as applicable), quantity, and date of disposition; and the name of any person who witnessed the destruction or disposal. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to account for the medications of two of two sampled residents (10 and 11) when they were discharged from the facility. Findings include:	S 652		

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S 652	Continued From page 57 1. Review of resident 10's care record revealed: *She was admitted to the facility on 1/2/25 and was discharged to the hospital on 6/16/25. *Facility staff administered to resident 10, twelve physician-ordered medications daily, and three as-needed medications. *Resident 10 self-administered two medications daily and three as-needed medications. *Resident 10's Medication Disposition record listed only one medication as destroyed on 8/14/25, related to resident 10's discharge from the facility. *There was no other documentation to support what had occurred with the resident's other staff and self-administered medications related to her discharge. 2. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B regarding resident 10's medications revealed: *She confirmed the medication that resident 10 was prescribed at the time of her discharge. *She was unsure what happened with those medications at the time of or after the resident 10's discharge. *She knew that those medications were not returned to the pharmacy, because the staff would have needed to destroy the medication or sent them with the resident when she was discharged. *She confirmed there should have been documentation to support what happened with those medications when resident 10 was discharged. 3. Review of resident 11's care record revealed: *He was admitted to the facility on 4/28/25 and discharged to a long-term care facility on 5/30/25. *Facility staff administered to resident 11, four	S 652	The RND provided education regarding the proper process for completing the Avera LTC disposition sheets, including accurate documentation, required signatures, and timely disposal procedures in accordance with regulatory standards. All licensed nurses and medication aides responsible for medication management and disposal received this education. Polices on medication destruction were reviewed with no changes or revisions needed. Audits will be conducted to ensure compliance with medication disposition processes. The following will be monitored: Completion and accuracy of Avera LTC disposition sheets. Proper documentation of medication destruction, including required signatures.Timeliness of medication disposal. CSD or designee to audit medication disposition documentation monthly for 6 months. CSD or designee will present audit findings at monthly QAPI meeting	4/5/26

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S 652	Continued From page 58 physician ordered medications daily and one as needed medication. *There was not a record of medication disposition found in his care record. 4. Interview on 2/19/26 at 9:30 a.m. and again at 2:30 p.m. with DON B revealed: *The the record of medication disposition was not located for resident 11 and the facility was not able to account for what occurred with the medications following his discharge. -The resident discharge had occurred shortly after she started at the facility. *She had implemented a process approximately six months ago for ensuring the medications were returned to the pharmacy or disposed of properly per the requirement of the regulation and documentation maintained.	S 652		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration.	S 685	Community RN completed review of all resident charts to identify all residents who self-administer medications. All identified residents were reviewed for valid physician orders for self-administration & documentation of quarterly assessments. Quarterly self-administration assessment due dates tracked by EMR. Admission checklist updated to include verifying self-administration orders. Edgewood self-administration policy reviewed, no changes made. CSD or designee to audit self-administration documentation monthly for 6 months. CSD or designee will present audit findings at monthly QAPI meeting	4/5/26

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This Administrative Rule of South Dakota is not met as evidenced by:
Based on interview, care record review, and policy review, the provider failed to ensure:
*The resident's ability to safely self-administer medications was assessed when the resident started to self-administer a medication and then quarterly for four of four sampled residents (1, 2, 10, and 13), who self-administered medications.
*The physicians' orders accurately reflected the medication approved for self-administration for one of four sampled residents (1) who self-administer medications.

Findings include:

1. Interview on 2/17/26 at 1:44 p.m. with resident 1 in her room revealed:
*She was diabetic (a condition involving disruptions in how the body regulates blood sugar) and completed her own insulin injections each week since she was admitted to the facility. Her insulin was stored in her refrigerator.
*She used a nebulizer (a device that converts liquid medication into an inhalable mist) to complete breathing treatments. She had two vials of the medication used in the nebulizer, but staff members usually brought the medication when it was due, or she requested it.

Review of resident 1's care record revealed:
*She was admitted on 8/25/25.
*A 12/5/25 physician's order for Ipratropium-Albuterol inhalation as-needed every six hours did not include self-administration of that medication.
-There was no documentation that a Medication

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Self-Administration Evaluation was completed for the resident's self-administration of Ipratropium-Albuterol.
*A 12/12/25 physician's order for Ozempic injections weekly starting on 12/29/25 did not include the resident's self-administration of that medication.
-A Medication Self-Administration Evaluation was completed for the weekly Ozempic injections on 1/26/26.

2. Review of resident 2's care record revealed:
*He was admitted on 5/16/25.
*A 9/13/25 physician's order for "CBD [Cannabidiol, a non-psychoactive compound derived from hemp] lotion to aching joints. May have at bedside."
-There was no documentation that a Medication Self-Administration Evaluation was completed for the resident's self-administration of CBD lotion.

3. Review of resident 10's care record revealed:
*She was admitted to the facility on 1/2/25.
*Her 3/6/25 Consultant Pharmacist's Report indicated " ...several of her medications identified as self administer." Self Administration assessments are required quarterly- I am unable to find one in her chart."
*Medications listed as self-administered daily were Citrucel Powder and Psyllium Fiber ordered on 1/3/25.
*Medications listed as self-administered as-needed were Antacid tablets and simethicone chewable tablets ordered on 1/2/25 and omeprazole ordered on 1/9/25.
*Her 7/1/25 Medication Self-Administration Evaluation did not indicate which medications resident 10 self-administered.
-There was no documentation of any additional Medication Self-Administration Evaluations

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S 685	Continued From page 61 having been completed. 4. Observation and interview on 2/18/26 at 8:55 a.m. with resident 13 in her room revealed: *She used a nebulizer for breathing treatments three times a day. *The medication aide would place the medication in the cup, turn on the machine for her, and leave the room until it was almost finished. -He returned to the room and ensured the medication in the cup was consumed, turned off the machine, and cleaned the nebulized medication cup. Interview on 2/18/26 at 9:05 a.m. with certified medication aide (CMA) F revealed: *He had just provided a nebulizer breathing treatment to resident 13. *He confirmed that he did not stay with the resident during her entire dose and was not aware that leaving the resident's room during the nebulizer treatment was considered self-administration. Review of resident 13's care record revealed: *She had been prescribed albuterol 0.083% (an inhaled medication used to relax the airway), three times a day on 2/6/26. *Her most recent Saint Louis University Mental Health Examination (SLUMS) cognitive score on 7/24/25 was 18, indicating she had moderate cognitive impairment. 5. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed: *She expected medication self-administration evaluations to be completed for each medication a resident self-administered, and that those evaluations would be completed when the resident started to self-administer a medication,	S 685		

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S 685	Continued From page 62	S 685		

quarterly, and with a significant change in the resident's status. She typically completed those evaluations.
*There was no Medication Self-Administration Evaluation completed for resident 1's Ipratropium-Albuterol inhalation nebulizer treatments because the facility stored the nebulizer medication vials and administered it to resident 1 when she requested it.
*She did not expect a staff member to supervise resident 1 when she completed her nebulizer treatments because they took about ten minutes to complete.
*She was unaware that resident 1 had nebulizer medication vials in her room.
*She confirmed a Medication Self-Administration Evaluation had not been completed for resident 2's CBD lotion.
*There was no documentation that an initial Medication Self-Administration was completed for resident 10 when she began self-administering her medications.
*She stated resident 10 discharged from the facility in June of 2025, and the 7/1/25 Medication Self-Administration Evaluation had been completed in May 2025 and was entered into the electronic care record late. It was the only Medication Self-Administration Evaluation completed for resident 10.
*She confirmed that resident 10's 7/1/25 Medication Self-Administration Evaluation did not indicate which medications resident 10 self-administered.

6. Interview on 2/19/26 at 2:30 p.m. with DON B revealed:
*She was not aware that nebulizer treatments without staff present were considered medication self-administration.
*She understood that a self-administration of

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11055	A. BUILDING: ______ B. WING ______	C 02/19/2026

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S 685	Continued From page 63 medication assessment for a nebulizer medication would identify if the resident was capable of consuming the entire dose without direct observation by staff. *A self-administration of medication assessment had not been completed for resident 13 with her nebulized albuterol medication. 7. Review of the provider's September 2025 South Dakota Admission Checklist revealed: *"All of the forms listed below must be completed within 24 hours of admission ...Medication Self-Administration Assessment." 8. Review of the provider's February 2026 Medication Administration policy revealed: *"Staff must remain with [the] resident during administration of all medication unless identified in the self-administration assessment." *"All medications will be handled, stored, and administered based on the state and Community requirements."	S 685		
S 820	44:70:09:08 Privacy And Confidentiality A facility shall provide for privacy and confidentiality for the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two computer screens in the memory care unit and east assisted living hallway were not left open for five of five observations by two of two observed staff (CMA N and R) and exposed confidential resident medical information. Findings include:	S 820	Staff are educated to activate privacy screens on computer when walking away from the med cart. Competency to be initiated on new hire orientation and with annual skills checklist. The CSD or designee will perform weekly audit for 4 weeks and quarterly for 6 months. These will be reviewed at the monthly QA meeting.	4/10/26

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S 820	Continued From page 64	S 820		

1. Observation on 2/17/26 at 1:45 p.m. in the memory care dining area revealed:
*There was a computer setting on the table open to an unidentified resident care record.
*Eight residents were in the dining area at the time of the observation.
*Certified medication aide (CMA) R observed the surveyor walking by the unattended computer and quickly removed the device.

2. Observation of the computer on the medication cart near the entrance to the east assisted living hallway revealed it was left open to an unidentified resident care record at the following times:
*On 2/18/26 at 7:22 a.m. with no staff present and multiple residents ambulating in the hall going to and from the dining room for breakfast.
*On 2/18/26 at 7:39 a.m. with no staff present and multiple residents ambulating in the hall going to and from the dining room for breakfast.
*On 2/18/26 at 10:35 a.m. with several residents ambulating in the hall.
*CMA N had been assigned to that medication cart and computer.

3. Observation on 2/19/26 at 8:28 a.m. of the east assisted living hall medication cart and computer screen revealed:
*The medication cart was just outside of resident room five.
*There were two resident care records visible on the computer screen.
*No staff were present.

4. Interview on 2/19/26 at 8:30 a.m. with CMA N confirmed:
*She had the computer screen open to the resident's care record and should have closed the

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S 820	Continued From page 65 computer or put it in privacy mode so that others were not able to read the resident's personal information. *She acknowledged that she had been in a hurry as she needed to provide assistance in the dining room with the serving of the morning meal. 5. Interview on 2/19/26 at 3:10 p.m. with executive director A revealed that it was the expectation that resident privacy and confidentiality be maintained with the use of their electronic medical record. 6. Review of the provider's October 2025 HIPAA (Health Insurance Portability and Accountability Act of 1996) Notice of Privacy Practices policy revealed: *" We are required by law to: Maintain the privacy of protected health information."	S 820		
S 850	44:70:09:11 Availability Of Survey Results Survey results, along with the corresponding plan of correction, shall be readily available and provided to residents and other individuals upon request. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to ensure the South Dakota (SD) Department of Health (DOH) licensure survey results and corresponding plans of correction were readily available to all residents and other individuals for review upon request. Findings include: 1. Interview on 2/18/26 at 10:17 a.m. with dining	S 850	A copy of the survey will be stored in a binder and made available in the lobby of the community.	4/5/26

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service director C revealed:
*He asked the surveyor if he could see the results of the previously completed SD DOH licensure survey.
*He was unaware whether the survey results were available at the facility.

2. Interview on 2/19/26 at 9:50 a.m. with executive director A regarding the availability of the previous SD DOH licensure survey results and corresponding plans of correction revealed:
*She had not seen any previous SD DOH licensure survey results or corresponding plans of correction at the facility.
*The previous SD DOH licensure survey results were unavailable at the facility for staff and residents to review.
*She would need to reach out to her supervisor to request a copy of the previous SD DOH licensure surveys and plans of correction.
*She was unaware that the SD DOH survey results and the corresponding plan of correction should have been available to staff and residents.