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
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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/Noncompliance A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:82, Community Living Homes, requirements for community living homes, was conducted on 9/26/24. Prosperity Hands, INC was found not in compliance with the following requirements: S013, S060, and S070.	S 000		
S 013	44:82:01:06 Resident evaluation and plan of care The owner or operator shall ensure that an evaluation of each resident's individualized and independent residential community living support needs is documented at the time of application for residency in the home, at least annually thereafter, and upon a significant change in condition requiring notification pursuant to § 44:82:06:04, to determine how the community living home can meet the needs of each resident and what services should be included in a plan of care jointly developed by the operator and the resident. The evaluation and plan of care shall be documented on a form approved by the department and maintained in each resident's record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure that a resident evaluation was updated on an annual basis for two of two sampled residents (1 and 2). Findings include: 1. Review of resident 1's records revealed: *He was admitted on 3/21/22. *His diagnoses included dementia, anxiety, seizure disorder, ADHD, major depressive disorder, fibromyalgia, and history of traumatic	S 013	Residents 1 and 2's evaluations have been updated. There are no other residents residing in the home. Going forward all residents' evaluations will be updated at least annually and with any signicant changes in the resident's condition by owner/UAP A. Owner/UAP B will ensure resident evaluations have documentation to show they have been updated annually or with significant changes. Those evaluations will be readily accessible to staff and others in the home. Owner/UAP A will audit to ensure all residents' evaluations are up-to-date and available in the home.	11/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Elizabeth Williams — 11/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 013	Continued From page 1 brain injury. *His 8/26/22 resident evaluation revealed: -"Full-time supervision because he forgets every five minutes." -"[Resident name] can physically complete all personal cares however requires prompts, cues, and supervision due to memory issues." *There were no additional evaluations for resident 1 found in the binder provided to surveyors.. 2. Review of resident 2's records revealed: *He was admitted on 11/30/22. *His diagnoses included Chronic Kidney Disease Stage IV, End-stage renal disease and dependent on dialysis, diabetes mellitus, peripheral vascular disease, vascular dementia, and anemia. *His undated resident evaluation revealed: -"Disabled and can't care for himself. Need 24/7 supervision." *There were no additional evaluations for resident 2 found in the binder provided to surveyors. Interview on 9/26/24 at approximately 12:30 p.m. with unlicensed assistive personnel (UAP) B revealed: *She was unable to provide information related to annual updates to the resident evaluations. *The resident evaluations were completed by owner/UAP A. *Owner/UAP A was not available at the time of survey since she was out of town. On 9/26/24 at 8:56 p.m. an email from owner/UAP A revealed: *She provided a copy of evaluations for residents 1 and 2. *The evaluation for resident 1 revealed: -It had been completed on 3/21/22 and revised on 3/21/23 and 3/21/24.	S 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 013	Continued From page 2 -"[Resident name] has three hours alone time, but with camera supervision." *The evaluation for resident 2 revealed: -It had been completed on 11/30/22 and revised on 11/30/23. -"Safe and reliable, maybe long term. Disabled and cannot care for himself. Need 24/7 supervision. Dementia." -"Updated 11/30/23 [Name of resident] needs less supervision. [Name of resident] is able to be left alone for three to four hours a day during the daytime." *This was not available to surveyors at the time of the on-site survey and was emailed approximately seven hours after the team exited the home. *There was no documentation provided related to how the determination was made that resident 1 and 2 were able to be left unsupervised.	S 013		
S 060	44:82:04:01 Daily Operations The community living home owner or operator is responsible for the daily overall operation of the home. The owner shall notify the department in writing of any change of ownership or change of location. The community living home owner, operator, or a care provider shall be available in the home as needed to effectively and appropriately meet the needs of the residents according to their respective care plans. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure a staff person was onsite in the home to ensure the safety and care needs for one of two sampled	S 060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 060	Continued From page 3 residents (1). Findings include: 1. Upon the surveyors' arrival to the home for the unannounced survey on 9/26/24 at 10:10 a.m. the following was revealed: *There were no cars parked in the driveway. *Surveyors knocked on the front door and no one answered. *Through the front door glass the house appeared to have no lights on and no one was seen. *Surveyors attempted to ring the doorbell and knocked on the door a few more times with no answer. On 9/26/24 at 10:13 a.m. the surveyors attempted to call owner/unlicensed assistive personnel (UAP) A regarding their arrival at the home for a survey. There was no answer and a message was left. Surveyors were waiting outside attempting to find another potential contact number for owner/UAP A when a vehicle pulled into the home's driveway at 10:25 a.m. At that time a younger female got out of the vehicle and headed to the home's front door. Surveyors identified themselves and the purpose of our visit and were allowed entry at that time. The female identified herself as UAP C. Interview and observation with UAP C revealed: *She reported she did not normally work there but was coming there to meet UAP B whom she identified as the manager of the home. *When asked if any residents were in the home at the time she stated she thought UAP B had taken them out. *She reported two residents currently lived there. *Surveyors asked for a brief tour of the home. *During the tour UAP C called UAP B on her	S 060	Unable to correct prior non-complaince. Resident 1 has not left the home without staff's knowledge since he moved into the home. He is not a wanderer and sleeps through the night. His evaluation has been updated and will be kept in the home to be readily accesible to staff and others. Owner/UAP A is responsible to ensure all residents' evaluations are up-to-date and individualized to meet their needs. Owner/UAP B will ensure all resident evaluations have documentation to show they are up-to-date. Owner/UAP A will audit to ensure all residents' evaluations are accurate, up-to-date, and available in the home.	11/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 060	Continued From page 4 phone while walking with the surveyors around the home: -Two bedrooms were upstairs with the doors closed. --One of those bedrooms was resident 2's and the other was a room that staff used. -Two bedrooms were downstairs with the doors closed. --One of those bedrooms had furniture but no one lived in it and the other room was resident 1's. -She knocked on resident 1's room door and stated he must be sleeping while talking with UAP B on the phone. --Resident 1 did not answer the door but the sounds of a television were heard through the door. *UAP C indicated that UAP B had driven resident 2 to an appointment and would be back to the home in about twenty minutes and she could answer the surveyors' questions when she got there. UAP B arrived to the home on 9/26/24 at 10:50 a.m. with a young female she identified as caregiver E. Interview with UAP B after arrival revealed: *The young female who arrived with was her daughter who also helped out at the home. *UAP B stated owner/UAP A was not available as she was out of state on vacation. *She stated she had to take resident 2 to his appointment that morning since he was not ready when the bus arrived to take him. *She had left resident 1 in the home when she had taken resident 2 to his appointment. -She confirmed no staff had been in the home until UAP C arrived. *She stated resident 1 could be left alone in the home for one hour at a time.	S 060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 060	Continued From page 5 -They had a Blink camera in the dining room and would have known if he had tried to leave. -He could also communicate with them by pushing a button on the camera which would alert to her mobile phone. *She confirmed resident 1 had short term memory concerns due to his medical history of a traumatic brain injury. *When asked if his records included his ability to be left alone in the home and she stated it should be in there. Review of resident 1's records revealed: *He was admitted on 3/21/22. *His diagnoses included dementia, anxiety, seizure disorder, ADHD, major depressive disorder, fibromyalgia, and history of traumatic brain injury. *His evaluation dated 8/26/22 revealed: -"Full-time supervision because he forgets every five minutes." -"[Resident name] can physically complete all personal cares however requires prompts, cues, and supervision due to memory issues." *There were no additional evaluations for resident 1 found in the binder provided to surveyors. *UAP B was not able to provide additional information regarding the evaluations and stated that they were completed by owner/UAP A. *There was no documentation found that indicated that resident 1 was able to be left in the home without supervision. On 9/26/24 at 8:56 p.m. an email from owner/UAP A revealed: *She provided a copy of an evaluation for resident 1. *The evaluation for resident 1 revealed: -It had been completed on 3/21/22 and revised on 3/21/23 and 3/21/24.	S 060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 060	Continued From page 6 -"[Resident name] has three hours alone time, but with camera supervision." *This was not available to surveyors at the time of the on-site survey and was emailed approximately seven hours after the team exited the home. *There was no documentation provided related to how the determination was made that resident 1 was able to be left unsupervised.	S 060		
S 070	44:82:05:01 Medication labeling, storage, and disposal The requirements for medications in community living homes include the following: (1) Medications and biologicals kept on the premises shall be labeled with the drug name, strength, and expiration date; (2) Medications shall be kept in a secure location or in the resident's room to prevent unauthorized access; (3) Medications requiring refrigeration may be stored in a refrigerator used for food storage if the drugs are stored in a sealed container and placed on the top rack or tray; (4) Medications shall be self-administered only by residents and family members, or by qualified personnel or care providers licensed or authorized to administer drugs; and (5) Outdated or discontinued medication shall be properly destroyed or disposed. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and medication label review, the provider failed to ensure: *Expired medications for residents 1 and 2 had been disposed of and had not been kept for use. *Unlicensed assistive personnel (UAP) (A, B, C,	S 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 070	Continued From page 7 and D) who assisted residents 1 and 2 with self-administration of their medications had been supervised and had oversight by a licensed nurse. *There was a process to ensure resident 1 and 2's medications were being taken as prescribed. Findings include: 1. Observation and interview on 9/26/24 at approximately 11:30 a.m. with UAP B during review of the medication cart and medication administration processes revealed: *Residents 1 and 2's medications were stored in a locked medication cart in the lower level living room. -Keys to the medication cart were available to the UAP staff that worked there. *UAP B indicated that staff A, B, C, and D assisted the residents with their medications. *She described the process to include: -The UAP brought the medication blister pack to the residents at the assigned times. -Then the resident would have punched out the medications from the day and time slot for that time frame. -After the residents took their medications staff would have returned the blister packs back into the medication cart. Continued observation, interview, and review of resident 1's medication blister packs in the second drawer of the medication cart with UAP B revealed: *Resident 1 had three weekly medication blister packs that were full with none of the individual medication blisters popped out. *There was another weekly medication blister pack that had all the individual blisters empty except for two blisters with medications in a Wednesday evening and bedtime areas.	S 070	The expired medications for resident's 1 and 2 will be disposed of by a licensed nurse or other qualified individual. A licensed nurse will be consulted to review the self-administration processes of resident's 1 and 2 to ensure safe medication administration and ensure their medications are being taken as prescribed. UAPs assisting with medication administration in the home will be appropriately trained and supervised by a licensed nurse. That process will have documentation to show the licensed nurse's oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 070	Continued From page 8 *All four of the weekly medication packs had pharmacy fill dates of 9/14/24. *UAP B indicated the resident had not taken the medications that were left in the Wednesday evening and bedtime blisters due to he was at an outing at those times. *There was no documentation to support: -What date or which Wednesday those medications were not taken. -Which date the first medications were taken out of the pack or what dates the weekly package was used for. *There was a 30-day blister pack containing 27 Tylenol tablets. The pharmacy label indicated to give that medication every six hours as needed and it had an expiration date of 6/23/24. -UAP B confirmed it was expired and it should have been disposed of. *When asked about the medication disposal process she said they would have asked the resident's nurse from the home health agency to assist with that. Continued observation, interview, and review of resident 2's medication blister packs in the third drawer of the medication cart with UAP B revealed: *Resident 2 had four weekly medication blister packs that were full with none of the individual medication blisters popped out. -Those packs had a pharmacy fill date of 9/11/24. *There was another weekly medication blister pack that was empty except for the medications left in blisters for a Thursday morning, evening, and bedtime areas. -That had a pharmacy fill date of 8/14/24. *There was no documentation to support: -What date or which Thursday those medications were not taken. -Which date the first medications were taken out	S 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 070	Continued From page 9 of the pack or what dates the weekly package was used for. *UAP B indicated the 8/14/24 pack was the one they were currently using and the resident had not taken his morning medications that day. *There was a 30-day blister pack of Arthritis Pain tablets. The pharmacy label indicated to give one every eight hours as needed and it had an expiration date of 5/29/24. -UAP B confirmed the medication was expired and should have been disposed of. Further observation and interview with UAP B regarding the above concerns revealed: *The weekly medication blister packs were filled by the pharmacy. -The pharmacy sent four blister packs for each of the resident's medications at a time to cover a whole month. *There was no documentation to support: -When the first or any medications were used from the packs for tracking purposes. -When medications were not taken for a certain date or time. -The medications were being given as prescribed. *She agreed there was no process to ensure the medications had been taken as prescribed. *She indicated the residents' assigned home health nurse had not: -Reviewed the processes for the residents' weekly medication blister packs. -Looked at the medication cart for expired medications. *There was no licensed nurse who supervised and provided oversight to the UAPs of the home. *Each resident had a home health nurse that visited them weekly for their individual needs. *In the past the residents' home health nurse reviewed their medication blister packs and helped with medication disposal if needed.	S 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71910	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPERITY HANDS, INC	904 S JAY CIRCLE SIOUX FALLS, SD 57103

(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 070	Continued From page 10 *Recently there had been different home health nurses coming and they had not always looked at the residents' medications during their visits. *When asked about the UAPs training or backgrounds she indicated they had received medication administration training elsewhere or at other jobs. *There was no documentation regarding the UAPs training related to medication administration in the home. *There was no documentation to support a licensed nurse was overseeing the medication administration practices and the UAPs who were assisting with medication administration.	S 070		