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
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 10/27/25 through 10/29/25. Edgewood Mitchell LLC was found not in compliance with the following requirements: S331, S450, and S603.	S 000		
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 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	S 331	Resident 1's 2-Step TB test will be completed as it was not in the medical record. Resident 2 and staff member were completed; however late. All resident's and staff are at risk. CSD, AED, 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 step 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. Edgewood TB policy reviewed, no changes made. CSD or designee will conduct monthly audits of new employee and resident records for 6 months. CSD will present audit findings in monthly QAPI meetings.	12/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 331	Continued From page 1 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 a Tuberculosis (TB) Mantoux Test (a screening tool used to detect latent tuberculosis infection) was completed following state regulation guidelines for: *Two of eight sampled residents (1 and 2). *One of ten sampled staff members (E). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *She admitted to the facility on 2/13/23. *There was no documentation of a TB skin test in her EMR being completed. Review of resident 2's EMR revealed: *She admitted to the facility on 7/24/25. *She was admitted to the hospital on 9/7/25 and returned to the facility on 9/8/25. *Immunization documentation listed that she had completed TB skin test on 9/29/25 and 10/6/25 that were negative. *Her TB skin tests were not completed within 21 days of admission to the facility. Review of employee personnel file for cook E revealed: *Cook E had been hired on 9/16/23.	S 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 331	Continued From page 2 *Her two-step TB testing was completed on 10/19/23 and 10/26/23. *They were not completed within 21 days of hire. 2. Interview on 10/28/25 at 3:07 p.m. with clinical services director (CSD) B revealed: Both she and licensed practical nurse (LPN) C complete resident admissions. *LPN C was responsible for administering the TB tests. *She was unable to locate resident 1's documented TB test. *She was unable to locate resident 2's documentation of TB testing being completed when admitted. *Resident 2's TB testing was completed upon her hospital return. Interview on 10/29/25 at 8:45 a.m. with LPN C revealed: *She was hired on 8/18/25. *She completed the two-step TB testing for staff upon hire and for residents upon admission. *She agreed that cook E TB testing had not been completed within 21 days of hire. Follow-up interview on 10/29/25 at 8:56 a.m. with CSD B revealed: *She agreed cook E's two-step TB testing had not been completed within 21 days of hire. *She expected the two-step TB testing to be completed within 21 days of hire for staff, and within 21 days of admission for residents. 3. Review of the providers revised September 2025 Tuberculosis policy revealed: *"With the licensed nurse, or executive director (if applicable), health services staff is responsible for establishing and managing processes in the community for infection control according to all	S 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 331	Continued From page 3 regulations that apply. Staff and residents must meet designated testing and immunization requirements related to infectious diseases." *"The community shall identify and fulfill the tuberculosis (TB) control and testing regulations that apply for staff and residents. If a skin test is required, the community shall administer, or coordinate for administration of a Mantoux skin test."	S 331		
S 450	44:70:06:01 Dietetic Services 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, record review, and policy review, the provider failed to ensure safe and sanitary dietetic service practices were followed to ensure effective temperatures and sanitization of items used to prepare and serve residents' food, proper hand hygiene practices, and food and beverage storage in one of one dining room and one of one kitchen. Findings include: 1. Observation on 10/27/25 at 1:50 p.m. of the refrigerator in the resident dining room revealed: *One gallon of milk that was opened and had a best by date of 10/23/25. *Two cranberry juices were opened and not dated with the open date. *One prune juice was opened and not dated with	S 450	In response to tag S 450: All residents & staff are at risk. All outdated food items and those lacking proper date markings (as specified in S450) were immediately discarded on 10/27/25. This correction was completed on-site during the South Dakota Health Department (SDHD) inspection. Dining Staff must clearly date mark every item immediately upon receipt. When an item is opened, write a large 'O' on the packaging along with today's date (e.g., O [11/11/25]). The Dining Services Director will conduct weekly food storage audits three times per week for the first week, followed by weekly audits for four weeks, then monthly audits for a two-month period to ensure sustained compliance. The ongoing audit frequency will be determined upon completion of this initial schedule.	12/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 450	Continued From page 4 the open date. *One tomato juice was opened and not dated with the open date. *One Armour brand package containing crackers, meat, and cheese had a use by date of 8/26/25. 2. Observation on 10/27/25 at 2:00 p.m. of the refrigerator in the kitchen revealed it contained: *One gallon of milk that was opened and had a best by date of 10/23/25. *One vanilla yogurt container that had a best by date of 10/22/25. *One jug of Simply raspberry lemonade that was opened and had a best by date of 7/26/25. 3. Observation on 10/27/25 at 2:10 p.m. of the walk-in cooler revealed: *Three cases of Gatorade Zero were stored under the shelf on the floor, and one of the Gatorade cases had a brown-white-green mold-like substance that had a pattern of circles on it. *The floor under the shelf where Gatorade was stored contained onion peels. *Two containers of vanilla yogurt with best by dates of 10/22/25. 4. Observation on 10/27/25 at 2:10 p.m. of the walk-in freezer revealed one box of potatoes was stored on the floor. 5. Observation on 10/27/25 at 2:10 p.m. of the pantry revealed it contained: *One box of butter pecan cake mix with a best by date of 12/20/24. *Two boxes of angel food cake mixes with a best by date of 10/8/25. *One box of Funfetti cake mix with a best by date of 12/16/24. *One box of dark chocolate fudge cake mix with a	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 450	Continued From page 5 best by date of 12/20/24. *Two boxes of corn bread mix with best by dates of 9/30/24. *One box of lemon bar mix with a best by date of 10/16/24. *One box of Casa Solana was stored on the floor with other boxes stacked on top of it. 6. Interview on 10/27/25 at 2:20 p.m. with dietary manager (DM) G, revealed she agreed that: *Food items that expired or past the product's best-by date should have been discarded. *All opened items should have an opened date written on them, including juices. *Once opened, juices were good for three days. *Food items were to be rotated every seven to ten days, checked for outdating/expiration. *All dietary staff were to check for and discard expired products in the kitchen and refrigerator in the residents' dining room. *Food items should not be stored on the floor. 7. Observation and interview on 10/28/25 at 10:26 a.m. with dietary assistant (DA) F while washing dishes revealed: *She rinsed dirty dishes in a tub of water and then put them in a dishwasher rack. *She then walked over to the three-compartment sink, where one of those compartments had a bucket of sanitizer solution in it, and she rinsed her hands in that solution. *She then grabbed clean dishes out of the dishwasher. *She thought the dishwasher's wash temperature needed to be at least 140 degrees, and the rinse temperature needed to be at least 180 degrees for effective cleaning. Those temperatures were to be checked and recorded daily. *The sanitizer level of the solution in the buckets was to be checked and recorded daily.	S 450	Coaching & Instruction on proper hand-washing techniques was provided to the (DA) F, immediately after the survey. Handwashing education was completed with all staff at the November 12th, All Staff Meeting. All residents and staff are at risk. All new and existing dining staff will complete a bi-annual hand hygiene refresher course via Edgewood's Relias training program. In addition, the CSD or designee will conduct Hand Washing Hygiene competencies upon hire and annually. The Dining Services Director will conduct weekly hand hygiene audits three times per week for the first week, followed by weekly audits for four weeks, then monthly audits for a two-month period to ensure sustained compliance. The ongoing audit frequency will be determined upon completion of this initial schedule.	12/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 450	Continued From page 6 *If correct temperatures or sanitization levels were not met, she would have told her manager. 8. Interview on 10/28/25 at 10:37 a.m. with DM G revealed: *She thought it was the facility policy to record the dishwasher temperatures and sanitizer levels weekly *The dishwasher was a high-temperature dishwasher, and required wash temperatures of 150 degrees and rinse temperatures of 180 degrees for effective cleaning. *She stated if correct temperatures or sanitization levels were not met or documented, she would not know if acceptable sanitization was reached. *She confirmed not reaching the acceptable wash and rinse temperatures or sanitization solution levels could put the residents at risk for illnesses. *She stated if the dishwasher was not meeting the required temperatures or the sanitizer solution was not meeting required sanitation levels, she would tell maintenance and/or call the chemical supply company to fix it. *Dietary staff should wash their hands with soap and water before touching clean dishes and she expected DA F to have washed her hands in soap and water and not rinsed them in the sanitizer bucket. *At the end of the interview, after looking at the dishwasher temperature and sanitizer level record sheets, she stated that it was to be done daily. Someone at the facility had told them it could have been weekly, so they changed their practice to weekly. 9. Observation and Interview on 10/28/25 at 12:00 p.m. with cook E in the kitchen revealed: *She rinsed the food thermometer under a soap solution and then rinsed it with water. *She was not aware that she was to sanitize it.	S 450	Dishwasher, Rinse and Sanitizer levels and temperatures. Dining Service Director immediately changed the recording of temperatures form to reflect the temperatures are to be taken 3 times a day, at breakfast, lunch and supper, initialed by the dining aide who takes the temperatures and the Dining Service Director will initial that the job was completed. The Dining Services Director will conduct weekly audits of the dishwasher, rinse and sanitizer temperatures and levels across all shifts three times per week for the first week, followed by weekly audits for four weeks, then monthly audits for a two-month period to ensure sustained compliance. The ongoing audit frequency will be determined upon completion of this initial schedule. Audits will be reviewed at monthly QAPI meetings. Education on standards in regards to dishwasher, rinse & sanitation levels & temperature requirements were completed with staff at the conclusion of the DOH survey on October 29th. All residents and staff are at risk. Sanitizing food thermometers-A dispenser of food thermometer sanitizer wipes has been placed in a central accessible location on the kitchen counter to ensure compliance with sanitation procedures & guidelines following the washing and rinsing of thermometers. Education on the proper process for sanitizing food thermometers was completed with staff at the conclusion of the DOH Survey on October 29th. Continuing audit review will be conducted at monthly QAPI meetings.	12/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 450	Continued From page 7 *There was a partial case of Campbell's soup stored on the floor by the three-compartment sink, behind a garbage can. 10. Interview with DM G, on 10/28/25 at 12:05 p.m. revealed she expected the food thermometer to be washed, rinsed, and then sanitized after use. 11. Review of the provider's dishwasher temping and sink sanitizing concentration log from 6/1/25 through 10/27/25 revealed: *The dishwasher did not meet the required temperatures on 9/25/25 at breakfast, and on 9/26/25 and 10/7/25 when there was only one temperature taken. *The dishwashing temperatures were not documented as being checked seventeen times in June 2025, twenty-six times in July 2025, thirty-four times in August 2025, thirty-eight times in September 2025, and sixty-five times in October 2025. *The sanitization solution was not documented ninety times in June 2025, ninety-three times in July 2025, eighty-eight times in August 2025, seventy-seven times in September 2025, and seventy-one times in October 2025. 12. Review of the providers' July 2024 Dining Services Policy and Procedure Manual revealed: *"Sanitation, current dish machine temperature or sanitizer log is posted and current." *"The dining services manager: -Trains and supervises the dining services team. -Operates a clean kitchen and dining room." *"Do not store any items on the floor. Keep storage areas free of crumbs, dirt, and odors. Keep refrigerator walls, shelves, floors, doors, and door seals free of food spills, dirt, or mold." *"Dishwashing procedures:	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 450	Continued From page 8 -Establish a daily procedure and check to see that it is properly done. -Note: Temperatures and sanitizer must be checked 3 times daily" *Walk-In refrigerator: "Inspect them regularly to see if cleanliness is maintained." *Hand Washing: -Everyone handling flood must wash their hands ...touching unclean surfaces ...." 13. Review of the providers November 2022 Hand Hygiene policy revealed: *"Hand hygiene is the most effective way to prevent the spread of disease. Hand hygiene should be done: ...after working with anything soiled ...."	S 450		
S 603	44:70:07:01(4) Policies And Procedures Each facility shall establish and implement written policies and procedures for medication control that include: (4) The proper disposition of medicines due to: (a) Resident discharge; (b) Resident death; (c) Outdated medication; or (d) The prescription being discontinued by the physician, physician assistant, or nurse practitioner. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure expired	S 603	Medication room cupboards and carts have been audited by CSD to identify any expired medications and disposed of properly. All residents are at risk of expired medications. CSD educated at all staff meeting on November 12th, on the policy of expired medications. Night Shift-CMA's will audit cart weekly, indefinitely. Lead CMAs & Nurses will audit carts and medication cupboards biweekly x 2 months and then monthly X 4 months to ensure compliance. CSD to review audits and report findings at monthly QAPI meetings.	12/01/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 603	Continued From page 9 medications were removed from one of one medication room. Findings include: 1. Observation and interview on 10/28/25 at 9: 38 a.m. with certified medication aide (CMA) D revealed: *Her medication cart appeared clean and organized with no expired medications. *She stated it was everyone's responsibility to look for expired items in the medication carts as well as the medication room, because the facility did not have a process set up to do so. *If she found an expired medication, then she would dispose of it properly. 2. Observation and interview on 10/28/25 at 10:14 a.m. in the medication room with clinical services director (CSD) B revealed: *Twenty-four of twenty-four 3cc (cubic centimeter) syringes with safety hypodermic needles had expired on 5/27/25. *Six of six packets of Cequa (cyclosporine ophthalmic solution 0.09%) had expired on 10/1/25. *A bag of daily psyllium fiber had expired on 8/28/25. *A bottle of furosemide 20mg (milligram) tablets had a use by date of 12/7/24. *A bottle of Aspirin had expired on 5/1/25. *Four of four boxes of Triamcinolone Acetonide ointment 0.025% had expired on 9/1/25. Interview with CSD B following the above observation in the medication storage room revealed: *She agreed that the expired medications should have been removed and destroyed appropriately. *She stated the nurses will sometimes go through	S 603		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68057	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MITCHELL, LLC	501 EAST SPRUCE STREET MITCHELL, SD 57301

(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 603	Continued From page 10 the medication room to look for expired medications. *The facility did not have a process for going through their medication room or their medication carts to check for expired medications. *She expected her staff to check expiration dates on medications and to dispose of them properly. *She did not specify how often she expected her staff to check expiration dates on medications. 3. Interview on 10/28/25 at 2:30 p.m. with licensed practical nurse C revealed that the facility did not have a process in place for checking for and disposing of expired medications. 4. Review of the provider's revised September 2025 Medication Storage policy revealed: * "G. All medications must be dated when opened and discarded on or prior to the expiration date. Expiration dates will be monitored to prevent outdated medications."	S 603		