

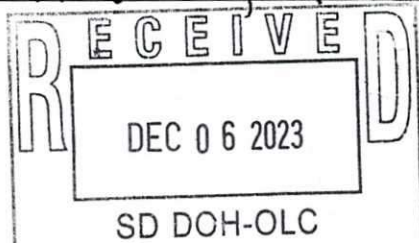
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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	<p>Compliance Statement</p> <p>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 11/6/23 through 11/7/23. Wel-Life At Elk Point was found not in compliance with the following requirements: S130, S172, S200, S331, S450, and S630.</p> <p>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 11/6/23 through 11/7/23. Areas surveyed included resident rights, nursing services, admission, transfer and discharge rights, and quality of life. Wel-Life At Elk Point was found in compliance.</p>	S 000		
S 130	<p>44:70:02:09 Infection prevention and control</p> <p>The infection prevention and control program shall utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control shall be maintained according to the requirements contained in 29 C.F.R. 1910.1030, July 1, 2006. The facility shall designate an employee to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of two observed medication aides (MA) (D) had performed hand hygiene when completing medication administration for four of four sampled</p>	S 130	<ol style="list-style-type: none"> 1. Resident 5,6,7,8 survey observation unable to be corrected, all residents potentially at risk. 2. Facility Executive Director/RN will review handwashing policy with all staff on Wednesday, November 29, 2023. Medication Aide D will complete handwashing competency with Executive Director/RN on or before December 15, 2023. 3. Executive Director will complete written handwashing audits on at least 3 staff weekly x 4 weeks and monthly x 3 months. 4. Results of written audits will be reviewed by Vice President of Operations for compliance and recommendations. 	12/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jennifer Wood, RN Executive Director</i>	TITLE Executive Director	(X6) DATE 12/16/2023
--	-----------------------------	-------------------------



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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 130	<p>Continued From page 1</p> <p>residents (5, 6, 7, and 8) during one of one observed medication pass. Findings include:</p> <p>1. Observation on 11/7/23 from 7:15 a.m. through 7:45 a.m. of MA D during medication administration on the 200 hallway revealed:</p> <ul style="list-style-type: none"> *She had not washed her hands or performed hand hygiene prior to or after administering medications for residents 5, 6, 7, and 8. *She touched the following items: <ul style="list-style-type: none"> -Drawer handles on the medication cart. -A computer screen. -Resident's room door handles. *She: <ul style="list-style-type: none"> -Pulled resident 5's medication cards from the medication cart. -Dispensed two medications into a paper cup. -Walked into resident 5's room and gave her the paper cup with medications. -Observed resident 5 take her medications. -Took the paper cup from resident 5 and discarded it into the garbage. -Went back to the medication cart in the hallway. -Did not perform hand hygiene. -Donned a pair of gloves and obtained resident 6's blood sugar. -Removed the gloves after obtaining resident 6's blood sugar and without performing hand hygiene she then donned a new pair of gloves. -Administered the resident's eye drops to both eyes. -Put the eye drops back in the medication cart and then removed those gloves and had not performed hand hygiene. -Opened the medication cart. -Pulled resident 7's medication cards from the medication cart. -Dispensed seven medications into a paper cup. -Walked into resident 7's room and gave him the paper cup with medications. 	S 130		



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
--	---

(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 130	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Observed resident 7 take his medications. -Took the paper cup from resident 7 and discarded it into the garbage. -Went back to the medication cart in the hallway. -Did not perform hand hygiene. -Pulled resident 8's medication cards from the medication cart. -Dispensed seven medications into a paper cup. -Walked into resident 8's room and gave him the paper cup with medications. -Observed resident 7 take his medications. -Took the paper cup from resident 8 and discarded it into the garbage. -Went back to the medication cart in the hallway. -Did not perform hand hygiene. <p>Interview on 11/7/23 at 9:15 a.m. with MA D regarding the above-observed medication pass revealed she agreed she should have:</p> <ul style="list-style-type: none"> *Performed hand hygiene between administering each resident's medications. *Washed her hands when she changed her gloves during the blood sugar check and before administering the eye drops. <p>Interview on 11/7/23 at 2:45 p.m. with executive director (ED) A revealed:</p> <ul style="list-style-type: none"> *Her expectations were for staff to perform hand hygiene or wash their hands prior to administering medications and providing care for each resident. *MA D had been trained on proper medication administration and infection control practices and should have followed the policy. <p>Review of the provider's November 2022 revised Handwashing/Hygiene policy revealed:</p> <ul style="list-style-type: none"> **5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...u. After removing gloves or 	S 130		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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 130	Continued From page 3 aprons." **6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: ...d. Before preparing or handling medications."	S 130		
S 172	44:70:02:17(6-7) Occupant protection The facility shall take at least the following precautions: (6) Prohibit the use of a portable space heater and portable halogen lamp, household-type electric blanket, or household-type heating pad in a facility. (7) Require that any light fixture located over a resident bed, over a bathing fixture or treatment area, in a clean supply storage area, or in any medication set-up area be equipped with a lens cover or a shatterproof bulb; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain protective shielding or shatterproof lights in the resident suite's bathrooms. Findings include: 1. Observation on 11/7/23 at 10:00 a.m. revealed one unshielded heat lamp and an unshielded incandescent bulb recessed into the ceiling of a vacant apartment's bathroom. It could not be determined if either lamp was shatterproof, but the maintenance staff B was not aware of the requirement for the bulbs to have been covered or shatterproof. Maintenance staff B also stated	S 172	<ol style="list-style-type: none"> 1. During survey review it was determined that an unoccupied resident bathroom had a light fixture that contained unshielded heat lamp and light bulbs. All resident bathrooms contain the same fixtures and bulbs, all residents at risk. 2. Maintenance Director will order and install shatterproof bulbs to replace all current bulbs in all resident bathrooms. To be completed on or before December 22, 2023. 3. Executive Director will visually inspect all resident bathrooms to ensure new bulbs in place on or before December 22, 2023, and complete a written audit. 4. Results of written audit will be reviewed by Vice President of Operations for compliance and recommendations. 	12/15/23

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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 172	Continued From page 4 the condition existed in each resident apartment bathroom.	S 172		
S 200	44:70:03:01 General fire safety Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition. An automatic sprinkler system is not required in existing facility unless significant renovations or remodeling occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure the automatic fire sprinkler system, fire alarm system, kitchen hood extinguishment system, and fire extinguishers were inspected and maintained as required. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports on 11/7/23 at 10:30 a.m. revealed the last annual sprinkler report was dated 7/20/22. Annual inspection was required. 2. Review of the provider's fire alarm system inspection reports on 11/7/23 at 10:40 a.m. revealed the last annual fire alarm report was dated 7/20/22. Annual inspection was required. 3. Review of the provider's fire alarm system inspection reports on 11/7/23 at 11:00 a.m. revealed the last kitchen extinguishment system	S 200	<ol style="list-style-type: none"> 1. No residents were identified in the deficiency. 2. The automatic sprinkler inspection, the fire alarm inspection, and the fire extinguisher inspections will be completed annually. The inspection will be completed or at least scheduled for completion by 12/15/23. The ED will re-educate the facility maintenance man on or before 12/15/23 regarding inspection time lines. 3. The Executive Director will complete audits annually to assure the required inspections are completed timely and are on file for review. 4. The Vice President of Operations will review the inspections to ensure compliance with time lines and any issues will be addressed. 	12/15/23

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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 200	Continued From page 5 report was dated 7/20/22. Kitchen hood extinguishment systems were required to have been inspected twice annually (NFPA 96, table 11.4). 4. Observation of the provider's fire extinguishers, beginning at 9:50 a.m. revealed the fire extinguishers annual maintenance date was July 2022. Fire extinguishers were required to have been serviced and inspected annually. Interview of maintenance staff B on 11/7/23 at 11:30 a.m. confirmed these findings.	S 200		
S 331	44:70:04:10 Tuberculin screening requirements Tuberculin screening requirements for healthcare employees or residents are as follows: (1) Each healthcare employee or resident shall receive an annual individual TB risk assessment that is documented and the two-step method of tuberculin skin or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12-month period prior to the date of admission or employment are considered a two-step. A TB blood assay test completed within a 12-month period prior to the date of admission or employment is considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation of the last skin or blood assay TB testing completed within the prior 12 months. Skin testing or a TB blood assay test is not necessary if documentation is provided of a	S 331	<ol style="list-style-type: none"> 1. No residents were identified in the deficiency. 2. The facility Executive Director will audit all Employee files for TB screening compliance and Records on or before December 15, 2023. All new hires will have 2 step TB completed per facility policy. 3. Executive Director will audit new hire files monthly (if any new hires during the month) for compliance with the TB policy. 4. Results of the audits will be reviewed by the Vice President of Operations. 	12/15/23

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
--	---

(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	<p>Continued From page 6</p> <p>previous positive reaction to either test. Any healthcare employee or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease.</p> <p>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 five of five sampled employees (E, F, G, H, and I) had a two-step tuberculin (TB) screening completed within fourteen days of there hire date or documentation of a prior screening within the past 12 months. Findings include:</p> <ol style="list-style-type: none"> 1. Review of employee E's personnel file revealed: *She was hired on 8/16/22. *There was no documentation that any type of TB screening had been completed. 2. Review of employee F's personnel file revealed: *She was hired on 2/20/23. *There was no documentation that any type of TB screening had been completed. 3. Review of employee G's personnel file revealed: *She was hired on 9/27/21. *There was no documentation that any type of TB screening had been completed. 4. Review of employee H's personnel file revealed: *She was hired on 1/20/23. *There was no documentation that any type of TB 	S 331		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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	<p>Continued From page 7</p> <p>screening had been completed.</p> <p>5. Review of employee I's personnel file revealed: *She was hired on 9/11/23. *There was no documentation that any type of TB screening had been completed.</p> <p>Interview on 11/7/23 at 1:15 p.m. with executive director (ED) A about the TB screening for staff revealed she: *Had been the ED for a year and a half. *Was still learning the human resource pieces of her position. *Did not realize the TB screens needed to have been completed for all employees within 14 days of their hire date. *Agreed the TB screening had not been completed for the above five employees.</p> <p>Review of the revised November 2022 Tuberculosis Prevention & Control Program policy revealed: **"1. The following components will be in place and monitored..." **"e. Screening programs for health care workers and residents, according to current risk classifications." **"Tuberculin Skin Testing (TST) for Health Care Workers (HCWs)." **"a. HCWs/volunteers who have not had a documented negative TST during the past 12 months should have a two-step TST. When the two-step method is used, only the initial (first step) must be read prior to employment. If the initial result is negative, a second test should be administered one to three weeks later."</p>	S 331		
S 450	44:70:06:01 Dietetic services	S 450	I. Survey review determined there was no open date label on various foods in walk in freezer, upright cooler, and dry storage. Labels and dates were immediately placed on the above foods.	12/15/23

2. Executive Director to review food storage policy with all dietary staff on Wednesday, November 29, 2023.
3. Dietary Supervisor will complete written food storage label audits by auditing the entire area identified in the deficiency- weekly x 4 weeks and monthly x 3.
4. Results of written audits will be reviewed by Executive Directory and or Vice President of Operations for compliance and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
--	---

(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	<p>Continued From page 8</p> <p>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.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain a safe and sanitary food service environment related to food storage and the dating of packaged food in one of one kitchen. Findings include:</p> <p>1. Observation and interview on 11/7/23 at 1:45 p.m. with dietary services manager (DSM) C in the kitchen revealed:</p> <p>a. Inside the walk-in freezer there was the following:</p> <ul style="list-style-type: none"> *An undated plastic bag full of hot dogs. *An undated plastic bag that contained two chicken fried steaks. *An undated plastic bag half full of breaded shrimp. <p>b. Inside the upright kitchen refrigerator there were two open undated packages of raw carrots.</p> <p>c. In the dry storage room at the back of the kitchen there was:</p> <ul style="list-style-type: none"> *An undated open 50 pound bag of flour. *An undated open 50 pound bag of corn starch. *An undated open bag of red raspberry gelatin. <p>Interview with DSM C regarding the food package dating process referred to above revealed: *She confirmed the food items were not dated when opened.</p>	S 450	
-------	--	-------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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
--------------------	--	---------------	---	--------------------

South Dakota Department of Health

<p>S 450</p>	<p>Continued From page 9</p> <p>*Consistent date marking of food packaging was expected to ensure the safety of the residents who consumed that food.</p> <p>Interview and policy review on 11/7/23 at 2:00 p.m. with executive director (ED) A regarding the food package dating process revealed:</p> <p>*It was her expectation that food packages would have an opened date on them to track quality and freshness.</p> <p>*The cook was responsible for dating a package when opened.</p> <p>*She agreed food package dating was not completed on a consistent basis.</p> <p>*There was no food storage policy.</p>	<p>S 450</p>		
<p>S 630</p>	<p>44:70:07:04 Storage and labeling of medications</p> <p>All drugs or medications shall be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for drug storage, and inaccessible to residents, or visitors at all times. Medications suitable for storage at room temperature shall be maintained between 59 and 86 degrees Fahrenheit (15 and 30 degrees centigrade). Medications that require refrigeration shall be maintained between 36 and 46 degrees Fahrenheit (2 and 8 degrees centigrade).</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to consistently monitor one of one medication refrigerator temperature containing multiple residents' insulin injection pens. Findings include:</p> <p>1. Observation and interview on 11/7/23 at 9:30</p>	<p>S 630</p>	<ol style="list-style-type: none"> 1. Survey review determined that medication storage temperatures were not being monitored and recorded. All medications in the medication refrigerator were at risk. 2. Clipboard immediately placed above temperature monitoring device by Executive Director. Medication storage policy to be reviewed by Executive Director/RN, Wednesday, November 29, 2023 with all staff. 3. Executive Director will complete written audits of medication refrigerator temperature recordings 3 times weekly x 4 weeks then monthly x 3. 4. Results of written audits will be reviewed by Vice President of Operations for compliance and recommendations. 	<p>12/15/23</p>

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____</p>	<p>(X3) DATE SURVEY COMPLETED C 11/07/2023</p>
---	---	---	---

<p>NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT</p>	<p>STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025</p>
---	--

<p>(X4) ID PREFIX TAG</p>	<p>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</p>	<p>ID PREFIX TAG</p>	<p>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</p>	<p>(X5) COMPLETE DATE</p>
---------------------------	---	----------------------	--	---------------------------

South Dakota Department of Health

S 630 Continued From page 10

a.m. with executive director (ED) A and maintenance staff B at the nurse's station revealed:

- *They knew there was a clipboard that should have been hanging on a nail next to the medication room door.
- *The clipboard was used for documenting the medication refrigerator temperatures.
- *The clipboard was found on a shelf across the hallway from the medication room.
- *The clipboard had a temperature log sheet attached to it with the month of May, no year, written at the top.
- *The last medication room refrigerator temperature recorded was May 19th, no year.

*Executive director (ED) A and maintenance B stated:

- The refrigerator was used for storing residents' insulin pens.
- The night staff were assigned to document medication refrigerator temperatures.
- There was no explanation as to why the clipboard was not hanging next to the medication door.
- Staff used the clipboard to document medication room refrigerator temperatures.
- They agreed the lack of temperature tracking for the medication room refrigerator posed a risk to the stored medications.
- There was no documentation since May, no year documented.
- They agreed staff had not followed the medication refrigeration policy.

Review of the November 2022 revised Medication Storage policy revealed:

**9. Refrigerated medications will be kept at a temperature of 36-46 Fahrenheit. Medications to be stored in a "cool place" may also be stored in a refrigerator unless otherwise indicated. The

S 630

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
---	---

(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 630

Continued From page 11

temperature must be checked and recorded daily."

S 630

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/21/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WEL-LIFE AT ELK POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST LINCOLN STREET ELK POINT, SD 57025
--	---

(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 revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 12/21/23 for deficiencies cited on 11/07/23. All deficiencies have been corrected, and no new noncompliance was found. Wel-Life At Elk Point is in compliance with all regulations surveyed.

{S 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE