DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435037	B. WING			С
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702		02/01/2024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
SS=E	with 42 CFR Part 483 for Long Term Care fa 1/30/24 through 2/1/24 was found not in comprequirement: F812. A complaint health sur CFR Part 483, Subpart Term Care facilities was through 2/1/24. Areas sufficient staffing, pers and medication admin Care was found in cor Food Procurement, Stc CFR(s): 483.60(i) (1) (2) §483.60(i) Food safety The facility must - §483.60(i) (1) - Procure approved or considere state or local authoritie (i) This may include fo from local producers, s and local laws or regul (ii) This provision does facilities from using progardens, subject to co safe growing and food (iii) This provision does facilities from using progardens, subject to co safe growing and food (iii) This provision does facilities from consuming foods §483.60(i)(2) - Store, provision does from consuming food serve food in accordar standards for food sen This REQUIREMENT	sonal care, infection control, istration. Clarkson Health inpliance. ore/Prepare/Serve-Sanitary) requirements. e food from sources and satisfactory by federal, es. od items obtained directly subject to applicable State lations. Is not prohibit or prevent oduce grown in facility impliance with applicable e-handling practices. In not procured by the facility. orepare, distribute and ince with professional vice safety. Is not met as evidenced	F 81	with an emphasis on residents' rights, for all residents that we so that the staff procurement, Store/Prepare/Se Sanitary. Staff education was completed with all staff present by Dietary Manager, Director of Nursing and Administrator on 02/07/2024 specific to Food Procurement, Store/Prepare/Se Sanitary. Throughout this proces interviews with staff and educatit was discovered all food produthat were stated to be found unopened or unlabeled had bee opened within 48-72 hours and used on a regular basis. Regard chemical storage, all chemicals were stored away, unopened as concealed on its own separate metal shelving away from food.	are, serve. Food rve- ed f rve- ess, tion acts en are ding	
aboratory d And	drea Knoll,	JPPLIER REPRESENTATIVE'S SIGNATURE		TITLE Executive Director		(X6) DATE 02/15/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

PRINTED: 02/12/2024 FORM APPROVED OMB NO. 0938-0391

AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		425007			C			
NAME OF PROMISE OF CHARLES		B. WING		10000				
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702					
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION			
F 812	by: Based on observation review the provider fa were appropriately pa away from cleaning of kitchen]. Findings include: 1. Observation on 1/3 kitchen revealed: a. In the dry food storachemicals were stored metal racks of food: *Prominence Heavy D *Suma Pan-Clean Def *Suma Break Up SC, Grease Release Clean *Medallion Stainless S *Suma-Diverpak Dish *Lime-A-Way Lime Sc *Suma Gloss Concent and stainless steel *Suma Cal X Descaler *Dawn Dish Soap *Monogram Glass Cle b. Inside the stand-up frozen donuts that was the air. c. Inside the upright re were unlabeled and ur hamburger patties, and were opened and exportant standard control of the province of	n, interview and policy iled to ensure food items ckaged and safely stored nemicals in [one of one o	F 81	Dietary Manager/designee will audit (started 02/05/2024) Food Procurement, Store/Prepare/Serve Sanitary food storage shelving for 1 week, and PRN, then 3 days a week for 1 week and PRN, then 1 day a week. for 1 week. and PR monthly thereafter and report find to QA committee, until the time at which QA committee determines that the audit findings are satisfact. Correction completion in labeling dating all food on 01/30/2024, chemicals were removed from Dry Food Storage room to a secured locked storage room on 02/05/2024. All other areas of dry food storage was audited and found to be in compliance. Addendum 02/22/2024 Policies for staff education reviewed on 02/07/2024 Were Food Storage and The flow of food, Purchasing, Receiving and Storage	N, N, ngs tory. 02/07/2024			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2024 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		OF DEFICIENCIES F CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	435037		B. WING			С			
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE					10	REET ADDRESS, CITY, STATE, ZIP CODE 15 MT VIEW RD APID CITY, SD 57702	<u> </u> 02	2/01/2024	
THE REAL PROPERTY AND PERSONS ASSESSED.	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
		*She was unsure if the store those chemicals *She confirmed the foupright freezer and the were not dated, labeled were opened. *It was her expectation opened food items in slabeled and dated. Interview on 2/1/24 at administrator A revealed *The food storage police were to have been stothe food items but did different location. *It was her expectation sealed and dated. *The dietary policies were viewed and updated. Review of the provider Policy and Procedure	ere was another location to od items observed in the e upright refrigerator/freezer ed, and sealed when they in that staff would store sealed bags that were 8:10 a.m. with ed: cy stated that chemicals red on a different rack than not need to be stored in a in that opened food items be were in the process of being . 's undated Food Storage Manual revealed: e clearly labeled, kept in en possible, kept in a d away from food." All foods should be	F	812				

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 435037			IA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE				REET ADDRESS, CITY, STATE, ZIP COD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETIC DATE
E0000	Initial Comments A recertification survey for copart 482, Subpart B, Subsect Preparedness, requirements facilities was conducted on 7/Care was found in compliance.	tion 483.73, Emergency for Long Term Care /22/2025. Clarkson Health	E0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Andrea KNOLL, LNHA

Executive Director

(X6) DATE 08/15/2025

FORM APPROVED

OMB NO. 0938-0391

AND PLAN OF CORRECTIONS IDENTIFICATION NUMBER: 435037 A. BUILDING 07/22/2025 B. WING	MPLETE
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD , RAPID CITY, South Dakota, 57702	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR REGULATORY	(X5) COMPLETION DATE
K0000 INITIAL COMMENTS A recertification survey was conducted on 7/22/2025 for compliance with 42 CFR 483.90 (a)8(b), requirements for Long Term Care facilities. Clarkson Health Care was found in compliance.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Andrea KNoll, LNHA

Executive Director

(X6) DATE 08/15/2025

PRINTED: 08/06/2025 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED. 62419 B. WING 07/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD **CLARKSON ASSISTED LIVING** RAPID CITY, SD 57702 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Compliance Statement S 000 Clarkson Health Care operates in A licensure survey for compliance with the compliance with all relevant regulations Administrative Rules of South Dakota, Article and professional standards in a 44:70, Assisted Living Centers, requirements for manner that ensures safe and assisted living centers, was conducted from appropriate care with an emphasis on 7/22/25 through 7/24/25. Clarkson Assisted Living residents' rights for all residents we was found not in compliance with the following serve. requirements: S296 and S352. S 296 44:70:04:04(1-11) Personnel Training S 296 These programs must be completed within thirty days of hire for all healthcare personnel and must In reference to S296 - This was an include the following subjects: isolated situation -Advance Directive Training was implemented immediately for all employees. An all-staff meeting (1) Fire prevention and response; will be held 08/21/2025 to review (2) Emergency procedures and preparedness, 08/21/2025 re-certification. Education will be including responding to resident emergencies provided as deems necessary. and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights: (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE ANALYS (NOLL, LNHA)

Any personnel whom the facility determines will have no contact with residents are exempt from

(11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and

retained in the facility.

TITI F

(X6) DATE

Executive Director

08/21/2025

South Dakota Department of Health

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUID				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		:		ATE SURVEY		
			A. BOILDING			OMPLETED		
		62410	B. WING					
62419			D. WING			07/24/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE				
CLARKS	ON ASSISTED LIVING	1015 MT	VIEW RD					
	PITTIES EIVING	RAPID C	ITY, SD 57702					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	E CORRECTION			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLETE		
IAG	NEGOLATOR OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE		
				DEFICIEN	CY)			
S 296	Continued From page	1	S 296					
	the training required b	v subdivision (8)						
	0 1	,						
		E ESSANS 24 244 4						
		le of South Dakota is not						
	met as evidenced by:	T						
	transcript review and	ersonnel records, training						
	transcript review, and interview, the provider failed to ensure training was completed on all the							
	required topics for adv	ance directives for five of						
	required topics for advance directives for five of five sampled employees (F, G, J, M, and N)							
	within 30 days of hire,	and annually						
Findings include:								
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
	1. Review of employee	personnel records						
	revealed:							
	*Employee F was hired			1				
	*Employee G was hire							
	*Employee J was hired	d on 7/9/24.		1				
	*Employee M was hire *Employee N was hire							
ĺ	Employee N was filler	u on 12/9/24.						
	2. Review of employee	training records and						
		ots revealed, there was no						
		ployees F, G, J, M and N						
	had received training on advanced directives.							
		at 9:00 a.m. with human						
	resources D revealed:							
		online training program for						
	employee-required trai							
		erified employees F, G, J,						
		ved training on advanced						
		ys of their hire or annually. for assigning the employee						
	training topics.	or assigning the employee						
1		advanced directives as a						
	-110 flad flot doolyffeu	davanoco dilectives as a						

South Dakota Department of Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED 62419 B. WING 07/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD **CLARKSON ASSISTED LIVING** RAPID CITY, SD 57702 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 296 Continued From page 2 S 296 training topic to any staff member. *She was not aware advanced directives was a required training topic. 4. Interview on 7/2425 at 12:45 p.m. with director of nursing (DON) B and administrator A revealed: *The provider used an online training program for employee-required training. *DON B confirmed employees F, G, J, M, and N had not completed training on advanced directives. *DON B verified advanced directives had not been assigned to any staff member to complete upon hire or annually. *Administrator A and DON B were not aware that

S 352

The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident

advanced directives was a required training.

S 352 44:70:04:13 Resident Admissions

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 30-day evaluation of care needs was completed for one of two sampled residents (1). Findings include:

- Review of resident 1's care record revealed: *Her admission date was 6/4/25.
- *Her admission evaluation of care needs was completed on 6/3/25, prior to her admission. *There was no documentation that her 30-day

PRINTED: 08/06/2025 South Dakota Department of Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: __ COMPLETED 62419 B. WING 07/24/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **CLARKSON ASSISTED LIVING** 1015 MT VIEW RD RAPID CITY, SD 57702 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES **PREFIX** PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 352 Continued From page 3 S 352 evaluation of care needs was completed. Interview with director of nursing B on 7/24/25 at 7:41 a.m. regarding resident 1's evaluation of care needs revealed: *She was responsible to complete the evaluation of care needs for residents. *She stated the 30-day evaluation of care needs for resident 1 was due to be completed on 7/4/25. *She verified the 30-day evaluation of care needs for resident 1 had not been completed. Review of the provider's 11/2/09 Resident Handbook revealed "Resident evaluations determine the level of services needed and are completed at the time of admission, 30 days after admission and at least annually or when change occurs in the resident's condition."

WXRS11