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| | 10691 | A. BUILDING: _____ B. WING _____ | C 08/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOUNTAIN FLOWER RETIREMENT HOME LLC | 1124 2ND STREET STURGIS, SD 57785 |

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| S 000 | Compliance Statement<br><br>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 8/25/26 through 8/26/26. Mountain Flower Retirement Home LLC was found not in compliance with the following requirements: S075, S095, S105, S165, S201, S295, S296, S305, S315, S331, S337, S443, S506, S680, and S685.<br><br>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 8/25/26 through 8/26/26. Areas surveyed included admission, transfer, discharge, potential for neglect, resident rights, quality of life, physical environment, and administration/personnel. Mountain Flower Retirement Home LLC was found in compliance. | S 000 | | |
| S 075 | 44:70:02:01 Sanitation<br><br>The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases to residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview, observation, label review, testing, and record review the provider failed to | S 075 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE April L. Huntley TITLE Administrator-Owner (X6) DATE 10/01/26
April Lynn Huntley Administrator-Owner 10/01/26

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| S 075 | Continued From page 1<br>disinfect and sanitize surfaces after they were cleaned:<br><br>Findings include:<br><br>1. Interview and observation on 8/25/26 at 3:11 p.m. with certified medication aide (CMA) B in the laundry room revealed they used a Scentsy brand cleaner for cleaning resident rooms. Sometimes they used bleach. She thought the bleach solution was made a couple times a week but was not for sure. She worked part-time at the facility and had never had to mix the bleach. There were multiple Scentsy products and one spray bottle labeled bleach.<br><br>2. Review of the Scentsy products labels revealed they were cleaners and did not indicate they killed bacteria and viruses. They were not registered with the environmental protection agency (EPA).<br><br>3. Testing of the Bleach bottle on 8/25/26 at 3:27 p.m. revealed it did not smell like a chlorine product. Testing with a chlorine test strip revealed the strip remained white and did not turn black or purple to indicate the presence of chlorine.<br><br>4. Observation and interview on 8/25/26 at 3:30 p.m. with CMA/cook C revealed she was carrying a container of Scentsy wipes. She referred to them as "disinfectant wipes." Review of the label revealed they were a cleaner, did not indicate they killed bacteria and viruses, and was not registered with the EPA. She was not aware the product was not a disinfectant.<br><br>5. Observation and interview on 8/25/26 at 3:45 p.m. in resident 8's room with personal care aide (PCA) D revealed she was cleaning resident 8's room with the Scentsy brand cleaners. She did | S 075 | S075 — Sanitation<br><br>Staff training on proper cleaning, sanitizing, and disinfecting procedures was completed on September 12, 2026. Ongoing training will remain a permanent part of staff orientation and continuing education.<br><br>The Administrator or designee will ensure that resident rooms, including resident 8's room, and shared areas are properly cleaned and disinfected. Ineffective or improperly prepared disinfectant solutions will be discarded. Staff will use appropriate EPA-registered disinfectants according to manufacturer instructions, including dilution, labeling, solution replacement, and required wet contact time. Cleaning products will not substitute for disinfectants.<br><br>The Administrator or designee will conduct and document weekly checks of cleaning practices, disinfectant supplies, and solution preparation on a permanent, ongoing basis. Any identified concerns will be corrected promptly, with additional staff instruction and follow-up to verify proper practice.<br><br>Responsible person: Administrator or designee.<br>Staff training completed: September 12, 2026.<br>Ongoing prevention: Permanent staff education and weekly monitoring. | 09/12/26 |

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| S 075 | Continued From page 2<br>not have a disinfectant with her in the cleaning supplies.<br><br>6. Interview on 8/25/26 at 4:15 p.m. with administrator/owner/CMA A revealed she was aware the Scentsy products were not a disinfectant. The staff were to follow the Scentsy cleaning products with chlorine bleach disinfectant. Disinfection with bleach was covered at the last staff meeting on 8/6/26.<br><br>7. Review of the 8/6/26 staff meeting minutes revealed "bleach-water bucket procedure. Approved mixture for 7.5% [percent] -8.25% unscented household bleach: add 5 tablespoons (1/3 cup) of bleach to 1 gallon of cool or room-temperature water. For a smaller amount, add 4 teaspoons of bleach to 1 quart [of] water. Prepare in a labeled container in a ventilated area while wearing appropriate gloves. Never mix bleach with ammonia, vinegar, acids, or any other cleaner. Prepare fresh bleach solution each day and discard the remaining solution safely at the end of the day, or sooner if visibly dirty or contaminated. Use each rag or cloth for one cleaning application only. Once used, place it directly into the designated soiled laundry container. No double-dipping: a used rag must never be returned to the bleach-water bucket. Obtain a clean rag for each new application. Pre-clean visible soil before disinfecting and keep the surface visibly wet for the bleach product's labeled contact time." | S 075 | Policies have been updated to include infection control vs. basic cleaning, proper uses of chemicals for infection control and the proper mixtures for chemicals. | 09/12/26 |
| S 095 | 44:70:02:05 Housekeeping Cleaning Methods And Equipment<br><br>The facility shall establish written housekeeping procedures for the cleaning of all areas in the | S 095 | | |

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| S 095 | Continued From page 3<br>facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, document review, and policy review, the provider failed to clean one of one ceiling exhaust vent in the public bathroom in the resident hallway.<br>Findings include:<br><br>1. Observation on 8/25/26 at 11:29 a.m. of the ceiling exhaust vent in the public bathroom in the resident hallway revealed it was about ninety percent covered with lint.<br><br>2. Interview on 8/25/26 at 4:20 p.m. with with administrator/owner/CMA A revealed she was not aware the vent in the bathroom was covered with lint. She thought it was on the monthly cleaning checklist. She agreed it should be maintained and cleaned.<br><br>3. Review of the monthly cleaning checklist revealed the ceiling exhaust vents in the bathrooms were not on the cleaning list.<br><br>4. Review of the undated Housekeeping Policy revealed "windows, vents, baseboards, walls. Minimum frequency: monthly observation and on an established rotation. Required actions: remove dust, cobwebs, splashes, and visible soil; report damage or moisture". | S 095 | S095 — Housekeeping Cleaning Methods and Equipment<br><br>The ceiling exhaust vent in the public bathroom in the resident hallway will be cleaned to remove accumulated lint and dust. All other facility exhaust vents will be inspected and cleaned as needed.<br><br>The written housekeeping procedures and monthly cleaning checklist will be updated to specifically include all bathroom ceiling exhaust vents. Assigned staff will document completion by date and initials. Vents will also be cleaned whenever visible buildup is identified. Written procedures will be available to housekeeping personnel.<br><br>Staff training regarding housekeeping responsibilities and vent cleaning was completed on September 12, 2026. Training will continue permanently through new employee orientation, ongoing education, and additional instruction whenever concerns are identified.<br><br>The Administrator or designee will inspect vents weekly for four weeks and monthly thereafter on a permanent, ongoing basis. Checklist completion and vent cleanliness will be verified. Missed cleaning will be corrected promptly, and findings, corrective actions, and additional staff instruction will be documented.<br><br>Responsible person: Administrator or designee.<br>Staff training completed: September 12, 2026.<br>Overall correction completion date: September 12, 2026<br>Ongoing training and monitoring: Permanent. | 09/12/26 |

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| S 105 | Continued From page 4<br><br>44:70:02:06 Food Service<br><br>Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation and interview, the provider failed to follow safety and sanitation procedures for food services regarding food stored in one of one basement, two of two wet wash rags left on the kitchen sink, and one of one observed resident vape device (a device placed into the mouth to inhale nicotine) stored in the kitchen in a safe in sanitary manner.<br><br>Findings include:<br><br>1. Observation on 8/25/26 at 11:20 a.m. in the basement revealed there was an exposed sewer line running across the ceiling of the basement. There were multiple cans of food stored directly under the exposed sewer line.<br><br>2. Interview on 8/25/26 at 12:25 p.m. with Administrator/owner/certified medication aide (CMA) A revealed she was not aware that foods were not permitted to be stored under an exposed sewer line. They had purchased the facility four years ago. Foods were stored under the exposed sewer line when they purchased the | S 105<br><br>S 105 | S105 — Food Service<br><br>Food stored beneath the exposed basement sewer line was relocated to an appropriate storage area protected from contamination. All food-storage areas were inspected for similar conditions. Food will remain out of the area beneath the exposed sewer line.<br><br>As an additional preventive measure, the facility plans to install protective guttering beneath the exposed sewer line when the contractor returns from attending a funeral. The Administrator will coordinate with the Department of Health to verify that the proposed installation is acceptable before using the area for food storage.<br><br>Used cleaning cloths are placed in the designated laundry container immediately after use. Cloths retained for repeated wiping are stored between uses in an appropriate sanitizer solution maintained according to product instructions. Wet cloths are not left on the kitchen sink.<br><br>The resident's vape device was moved to the resident's personal storage bin during the survey. The affected spoon rest and contaminated food-contact surfaces were cleaned and sanitized. Vaping devices and other personal belongings are stored and charged in designated locations away from food, utensils, and food-preparation areas.<br><br>Staff training was completed on September 12, 2026, addressing sanitary food storage, proper handling of cleaning cloths, sanitizer use, and separation of personal belongings from food-service areas. Written procedures are available to staff. Training will continue permanently through new employee orientation, ongoing education, and additional instruction whenever concerns are identified.<br><br>The Administrator or designee will check kitchen sanitation daily and all food-storage areas weekly on a permanent, ongoing basis. Findings and corrective actions will be documented. Identified concerns will be corrected promptly, with additional staff instruction and follow-up as needed.<br><br>Responsible person: Administrator or designee.<br>Staff training completed: September 12, 2026.<br>Corrective actions completed: September 12, 2026, with food relocated.<br>Additional gutter installation: Pending contractor's return; installation date to be documented.<br>Ongoing training and monitoring: Permanent. | 09/12/26 |

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| S 105 | Continued From page 5<br>facility. She agreed there were cans of food stored under the exposed sewer line.<br><br>3. Observation and interview on 8/25/26 at 3:18 p.m. in the kitchen with certified medication aide (CMA) B revealed there were two wet wash rags stored at the sink. She did not know those wet wash rags sould harbor and grow bacteria and should have been stored in sanitizer solution when they were not in use.<br><br>4. Observation and interview on 8/25/26 at 3:25 p.m. in the kitchen with CMA/cook C revealed there was a resident's vape smoking device stored on the spoon rest (a plastic device used to set your in-use spoons that were used to stir or cook with) in the kitchen. She was not sure how long or why the vape was placed on the spoon rest. The staff recharged the resident's vape for him but did not know why the vape was stored there. She removed the vape and put it in the resident's storage bin for his personal items.<br><br>5. Interview on 8/25/26 at 4:20 p.m.with administrator/owner/CMA A with administrator/owner/CMA A revealed she was not aware they were storing wet wash rags at the kitchen sink. Those rags should have been sent to the laundry room when the staff were done cleaning with them. She was not aware the vape was stored in the cooking area and on the spoon rest. She agreed the vape would have been contaminated with saliva and should not have been stored in the kitchen where food was prepared. | S 105 | | |
| S 165 | 44:70:02:17 Occupant Protection<br><br>Each facility must be constructed, arranged, | S 165 | | |

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| S 165 | Continued From page 6<br>equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation and interview, the provider failed to store healthcare products in a sanitary manner in one of one basement.<br><br>Findings include:<br><br>1. Observation on 8/25/26 at 11:20 a.m. in the basement revealed there were four packages of McKesson ultra under pads and a garbage bag full of Tena Pro skin classic wipes stored on the floor in the basement. Those items could be used for the care of residents and could come in contact with skin. They were to be stored up off the floor on a clean shelf or in a clean container. There was an exposed sewer line running across the ceiling in the area where the supplies were stored on the floor.<br><br>2. Interview on 8/25/26 at 12:25 p.m.Administrator/owner/certified medication aide (CMA) A revealed she was aware that those items should not be stored on the floor. Those items were overstock. When those supplies were moved to the basement, there was no room to store them on the shelves at that time.<br><br>3. Observation on 8/25/26 at 1:30 p.m. revealed the four packages of McKesson ultra under pads and garbage bag full of Tena Pro skin classic | S 165 | S165 — Occupant Protection<br><br>The four packages of underpads and the bag of wipes identified during the survey were removed from the basement floor and placed on shelving on August 25, 2026, as verified by the surveyor. The immediate storage correction was completed during the survey.<br><br>All resident-care supplies, including overstock, will be maintained off the floor on clean shelving or in clean containers and protected from contamination, including exposed sewer lines. Supplies with contaminated or compromised packaging will be discarded. Staff will notify the Administrator when additional storage space is needed.<br><br>Staff training on sanitary storage, protection of packaging, and proper placement of newly received supplies was completed on September 12, 2026. Training will continue permanently through new employee orientation, ongoing education, and additional instruction whenever concerns are identified.<br><br>The Administrator or designee will inspect all resident-care supply-storage areas weekly on a permanent, ongoing basis. Findings and corrective actions will be documented. Improperly stored supplies will be relocated promptly, with additional staff instruction and follow-up as needed. Policies were reviewed and updated.<br><br>Responsible person: Administrator or designee.<br>Storage correction completed: August 25, 2026, during the survey.<br>Staff training completed: September 12, 2026.<br>Ongoing training and monitoring: Permanent. | 9/12/26 |

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| S 165 | Continued From page 7<br>wipes were removed from the floor and stored on shelves. | S 165 | S201 — General Fire Safety<br>The facility has arranged for its contractor to install appropriate self-closing hardware on resident bedroom doors 1 through 6 upon returning from attending a funeral. Installation is completeas of October 09, 2026. All other resident bedroom doors will be inspected for the same condition, and any missing or defective hardware will be addressed.<br>Pending installation, the Administrator will coordinate interim fire-safety precautions with the applicable fire-safety authority and instruct staff on those precautions.<br>Following installation, each affected door will be tested to verify that it closes fully and latches properly without manual assistance. Installation and operational checks will be documented.<br>Staff training was completed on September 12, 2026, addressing keeping doors free of obstructions, not disabling self-closing devices, and promptly reporting malfunctioning hardware. Training will continue permanently through new employee orientation, ongoing education, and additional instruction as needed.<br>The Administrator or designee will check resident bedroom door operation weekly for four weeks following installation and monthly thereafter on a permanent, ongoing basis. Findings, repair requests, and completed repairs will be documented. Malfunctions will be addressed promptly.<br>Responsible person: Administrator or designee, with contractor.<br>Target completion date: October 31, 2026.<br>Staff training completed: September 12, 2026.<br>Ongoing training and monitoring: Permanent. | 10/09/26 |
| S 201 | 44:70:03:02 General Fire Safety<br><br>Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation and interview, the provider failed to provide self-closing hardware on six of six observed resident bedroom doorss (1, 2, 3, 4, 5, and 6).<br><br>Findings include:<br><br>1. Observation on 8/25/26 at 1:00 p.m. revealed the doors to bedrooms 1, 2, 3, 4, 5, and 6 were not equipped with self-closing devices. The doors would stay in an open position.<br><br>2. Interview on 8/25/26 at 4:45 p.m. Administrator/owner/certified medication aide (CMA) A revealed the doors were like that when she had purchased the building four years ago. She was not aware the doors to resident rooms were required to be self-closing. | S 201 | | |

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| S 295 | Continued From page 8 | S 295 | S295 — Personnel Training | 9/12/26 |
| S 295 | 44:70:04:04 Personnel Training<br><br>The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on personnel file review, interview, and annual training curriculum review, the provider failed to ensure four of six sampled employees (A, B, E, and F) had completed the required training topics.<br><br>Findings include:<br><br>1. Review of employee A's personnel file revealed she was hired on 9/8/22 as the owner, administrator, and certified medication aide (CMA). The 2026 inservice record sheet within her file was blank. There was no documentation of annual training completed in 2025.<br><br>2. Review of employee B's personnel file revealed she was hired on 11/24/23 as a CMA. The 2026 in-service record sheet was marked complete on 6/4/26 for emergency procedures and preparedness, but all other sections remained blank. There was no documentation of annual training completed in 2025.<br><br>3. Review of employee E's personnel file revealed she was hired on 7/6/26 as a personal care aide (PCA). The 2026 in-service record sheet was marked complete on 6/11/26 for emergency procedures and preparedness, but all other sections remained blank. There was no | S 295 | All outstanding required training for employees A, B, E, and F and other applicable healthcare personnel was completed by September 12, 2026. Staff education will continue monthly on a permanent, ongoing basis. The annual training schedule will ensure that every healthcare employee completes all required subjects annually.<br><br>Required education includes fire safety, emergency preparedness, infection control, accident prevention, resident rights, confidentiality, mandatory reporting, nutrition and hydration, abuse and neglect prevention, cognitive impairment and challenging behaviors, oxygen safety, and education specific to residents' needs.<br><br>A formal orientation program, individual training records, and a master tracking log will identify required subjects, actual completion dates, and next due dates. Attendance and the instructor or training source will be documented. Records will be retained in an organized, retrievable system with backup copies. Historical training will only be recorded as completed when supported by documentation.<br><br>The Administrator or designee will review training records monthly, arrange education before it becomes overdue, and follow up on missing documentation. Findings and corrective actions will be documented.<br><br>As an additional personnel compliance measure, Office of Inspector General (OIG) exclusion screenings are current for all employees. The facility will repeat these screenings quarterly and retain documentation of the results.<br><br>Responsible person: Administrator or designee.<br>Overall training correction completed: September 12, 2026.<br>Ongoing education and training-record reviews: Monthly and permanent.<br>OIG exclusion screenings: Current; quarterly checks ongoing.<br><br>Training policies were reviewed at the 9/12/26 | |

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| S 295 | Continued From page 9<br>documentation of annual training completed in 2025.<br><br>4. Review of employee F's personnel file revealed he was hired on 9/8/22 as the bookkeeper and CMA. The 2026 in-service record sheet within his file was blank. There was no documentation of annual training completed in 2025.<br><br>5. Interview on 8/26/26 at 8:50 a.m. with owner/administrator/CMA A confirmed that employee's B and E had only completed one section of the required annual training topics. Employees B and E did not complete training in 2026 for fire prevention and response, infection control and prevention, accident prevention and safety procedures, resident rights, confidentiality, incidents and diseases subject to mandatory reporting, nutritional risks and hydration, abuse and neglect, caring for residents with cognitive impairment or challenging behaviors, and oxygen. Employees A and F did not complete any of the required training topics in 2026.<br><br>The documentation for annual training provided in 2025 was requested at the time of the interview. Owner/administrator/CMA A could not locate the documentation and stated that it was likely not retained and was shredded.<br><br>6. Review of the provider's undated annual training curriculum identified that the topics of resident rights and abuse prevention, infection control, fire safety and emergency preparedness, medication management, dementia care, ADL (activities of daily living) care and safe transfers, nutrition and hydration, documentation and reporting, and behavior management were to be completed annually. | S 295 | | |

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| | 10691 | A. BUILDING: _____ B. WING _____ | C 08/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOUNTAIN FLOWER RETIREMENT HOME LLC | 1124 2ND STREET STURGIS, SD 57785 |

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| S 296 | Continued From page 10 | S 296 | S296 — Personnel Training Within Thirty Days of Hire | |
| S 296 | 44:70:04:04(1-11) Personnel Training<br><br>These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects:<br><br>(1) Fire prevention and response;<br>(2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives;<br>(3) Infection control and prevention;<br>(4) Accident prevention and safety procedures;<br>(5) Resident rights;<br>(6) Confidentiality of resident information;<br>(7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;<br>(8) Nutritional risks and hydration needs of residents;<br>(9) Abuse and neglect;<br>(10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and<br>(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.<br><br>Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8).<br><br>This Administrative Rule of South Dakota is not | S 296 | Initial corrective training was completed by September 12, 2026, including the outstanding oxygen training for employees C and D and fire prevention and response training for employee D. Training records will reflect actual completion dates.<br><br>The Administrator will review all current healthcare personnel files to verify completion and documentation of required orientation subjects. The written onboarding program and checklist will require all applicable subjects identified in 44:70:04:04(1–11) to be completed within thirty days of hire. Required subjects will not be deferred to the sixty- or ninety-day portions of orientation.<br><br>Training will address fire prevention and response; emergency preparedness and advance directives; infection control; accident prevention; resident rights; confidentiality; mandatory reporting; nutrition and hydration; abuse and neglect; communication and problem-solving for residents with cognitive impairment or challenging behaviors; and education specific to residents' needs, including oxygen safety.<br><br>The Administrator or designee will establish training deadlines at hire and review each new employee's orientation checklist weekly until complete. Records will identify subjects, actual completion dates, instructor or training source, and attendance.<br><br>Staff education will continue monthly on a permanent, ongoing basis, with all required subjects covered annually. The Administrator or designee will review training records monthly and document any findings, corrective actions, and follow-up.<br><br>Responsible person: Administrator or designee.<br>Initial corrective training completed: September 12, 2026.<br>Ongoing staff education and training-record reviews: Monthly and permanent. | 9/12/26 |

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| S 296 | Continued From page 11<br>met as evidenced by:<br>Based on personnel file review, interview, and onboarding program review, the provider failed to ensure that two of six sampled employees (C and D) completed the required training topics within thirty days of their hire date.<br><br>Findings include:<br><br>1. Review of employee C's personnel file revealed she was hired as a certified medication aide (CMA) and cook on 3/21/26. She had completed training on fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety, resident rights, confidentiality, incidents subject to mandatory reporting, nutritional risks and hydration, abuse and neglect, and assisting residents with cognitive impairment or challenging behaviors on 6/3/26. There was no documentation that training on oxygen was been provided.<br><br>2. Review of employee D's personnel file revealed she was hired as a personal care aide (PCA) on 5/15/26. She had completed her training on 6/4/26 except for fire prevention and response and oxygen.<br><br>3. Interview on 8/26/26 at 9:45 a.m. with owner/administrator/CMA A revealed that she was aware that employee C did not completed her education within thirty days of her hire date and that employee D was missing several areas of the required education. Oxygen training was not completed in the facility for the last several years and she was attempting to arrange this training through a local respiratory service and oxygen supplier. Owner/administrator/CMA A acknowledged the training program for | S 296 | | |

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| S 296 | Continued From page 12<br>employees needed to be revamped.<br><br>4. Review of the provider's undated Full Compliance System: Onboarding, Training, and Policy Integration revealed that the topics of resident rights, abuse reporting, infection control, and emergency reporting were to be completed with new employees within the first thirty days of being hired. The remainder of the onboarding materials were presented to the employees within sixty and ninety days. | S 296 | | |
| S 305 | 44:70:04:05 Personnel Health Program<br><br>The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on personnel file review, interview, and policy review, the provider failed to ensure two of two newly hired employees (C and D) were evaluated by a licensed health professional to ensure they were free from communicable diseases within fourteen days of their hire date.<br><br>Findings include:<br><br>1. Review of employee C's personnel file revealed she was hired on 3/21/26 as a certified medication aide (CMA) and cook. She was evaluated by a licensed health professional, registered nurse (RN) G, on 5/4/26. | S 305 | S305 — Personnel Health Program<br><br>The Administrator will review all current personnel files and ensure that any missing or incomplete health evaluations, including employee D's evaluation, are completed by a licensed health professional by October 14, 2026. Employee C's evaluation completed May 4, 2026, will be retained in the personnel record.<br><br>Evaluations will address reportable communicable diseases that pose a threat to others and include assessment of previous vaccinations and tuberculin skin tests. Documentation will reflect the actual evaluation date and will be maintained confidentially.<br><br>For future employees, the Administrator will ensure that required health evaluations are completed before assignment to duties or within fourteen days after employment. The hiring checklist will identify the start date, evaluation deadline, scheduled appointment, and actual completion date. An alternate licensed health professional will be arranged if the assigned professional is unavailable.<br><br>The Administrator and personnel responsible for onboarding will review the personnel health policy and their responsibilities for scheduling evaluations, tracking deadlines, and retaining documentation.<br>Facility nurse to complete Health evaluations<br><br>Policies have been reviewed.<br><br>The Administrator or designee will review pending evaluations weekly until complete and audit personnel health documentation monthly on a permanent, ongoing basis. Findings, follow-up, and corrective actions will be documented.<br><br>Responsible person: Administrator or designee, with a licensed health professional.<br>Target completion date for current employees: October 14, 2026.<br>Future employee evaluations: Before assignment to duties or within fourteen days after employment.<br>Ongoing monitoring: Monthly and permanent, with weekly tracking of pending evaluations. | 10/01/26 |

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| S 305 | Continued From page 13<br><br>2. Review of employee D's personnel file revealed she was hired on 5/15/26 as a personal care aide (PCA). There was no documentation that she was evaluated by a licensed health professional following her hire date.<br><br>3. Interview on 8/26/26 at 9:45 a.m. with owner/administrator/CMA A revealed that she acknowledged that employees C and D were not evaluated by RN G within fourteen days of their hire date to ensure they were free from communicable diseases. She expected that this would have been completed. RN G was not available during the survey and had announced her upcoming retirement. Owner/administrator/CMA A verbalized that this expectation would be emphasized with the new facility nurse once they were hired.<br><br>4. Review of the provider's 8/26/26 Employee Health policy revealed, "Before assignment to duties or within 14 days after employment, each employee must be evaluate by a licensed health professional for freedom from a reportable communicable disease that poses a threat to others." | S 305 | Administrator to will ensure for future employees that required health evaluations are completed before assignment of duties or within fourteen days after employment.<br><br>Facility nurse to complete health evaluations.<br><br>all policies were reviewed 9/12/26 and 10/01/26 | 10/01/26 |
| S 315 | 44:70:04:07 Prevention And Control Of Influenza<br><br>Each facility shall arrange for an influenza vaccination to be completed annually for each resident. Each resident shall be offered influenza vaccine when the resident is admitted and annually during the influenza season. Documentation of the vaccination or refusal must be recorded in the resident's care record. | S 315 | | |

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| S 315 | Continued From page 14<br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review and interview, the provider failed to ensure documentation was completed for two of four sampled residents (5 and 6) that they were offered the influenza vaccination, or if they refused it annually.<br><br>Findings include:<br><br>1. Review of resident 5's electronic medical record (EMR) revealed he admitted to the facility on 4/27/14. There was no documentation that he was offered or refused the influenza vaccination annually.<br><br>2. Review of resident 6's EMR revealed he was admitted to the facility on 3/28/25. He had received the influenza vaccination on 10/30/24 prior to admission. There was no documentation that he was offered or refused the influenza vaccination annually after he admitted to the facility.<br><br>3. Interview on 8/25/26 at 4:02 p.m. with owner/administrator/certified medication aide A regarding residents 5 and 6 revealed they should have been offered the influenza vaccination annually, and were not.<br><br>4. An influenza policy was requested on 8/25/26 at 5:00 p.m. and was not provided by the end of the survey. | S 315 | S315 — Prevention and Control of Influenza<br><br>The facility has requested influenza vaccination or refusal documentation from the VA and pharmacy and is awaiting the faxed records. The Administrator or facility nurse will review and place the documentation in the care records of residents 5 and 6 and any other residents with missing records. This process will be completed by October 15, 2026.<br><br>All current residents' records will be reviewed to verify current-season vaccination or refusal documentation. If the requested records do not establish current-season status, the resident will be offered vaccination and the response documented. Vaccination will be arranged for residents who consent, with follow-up tracked until administration is documented.<br><br>A written influenza vaccination policy will be established and implemented to address offering vaccination upon admission and annually during influenza season, arranging vaccination, obtaining outside records, and documenting vaccination or refusal in each resident's care record.<br><br>Staff responsible for admissions and resident health records will receive instruction on the policy and documentation requirements. An admission checklist and annual vaccination tracking log will identify each resident's status and outstanding follow-up.<br><br>The Administrator or designee will follow up on pending records until resolved and review the vaccination tracking log monthly during influenza season. Documentation will also be verified for each new admission. Findings and corrective actions will be recorded. This process will remain permanent and ongoing.<br><br>Responsible person: Administrator or designee, with facility nurse.<br>Target completion date: October 15, 2026.<br>Ongoing monitoring: Each admission and monthly during influenza season, permanently. | 10/01/26 |
| S 331 | 44:70:04:10(1) Tuberculin Screening... Requirements<br><br>Tuberculin screening requirements for healthcare personnel and residents are as follows: | S 331 | | |

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| S 331 | Continued From page 15<br><br>(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 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;<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on personnel file review, interview, and policy review, the provider failed to ensure two of two newly hired employees (C and D) had received a tuberculin (TB) baseline screening and | S 331 | S331 — Tuberculin Screening Requirements<br><br>The facility will establish an account with Monument Health to coordinate required TB testing. Employees C and D will complete documented individual TB risk assessments and appropriate baseline testing, unless a documented exception under the cited administrative rule applies. Outstanding screenings will be completed no later than October 30, 2026, and sooner if the account is established and appointments are available.<br><br>The Administrator will review all current healthcare personnel and resident records for required TB screening documentation. Missing assessments or testing will be arranged, and any applicable testing exception will be supported by documentation. Actual assessment dates, testing dates, and results will be retained confidentially.<br><br>For future employees and residents, screening will be completed according to 44:70:04:10(1), including a documented individual TB risk assessment and two-step tuberculin skin testing or a TB blood assay within twenty-one days of employment or admission. Qualifying prior testing and documented exceptions will be accepted as specified in the rule. Newly recognized positive results will receive the required medical evaluation and chest X-ray.<br><br>The onboarding and admission checklists will identify the start date, screening deadline, scheduled appointments, and actual completion dates. The Administrator will coordinate appointments with Monument Health and arrange an alternate provider if account setup or scheduling would delay completion beyond the applicable deadline.<br><br>The Administrator or designee will review pending screenings weekly until complete and audit screening documentation monthly on a permanent, ongoing basis. Findings, follow-up, and corrective actions will be documented.<br><br>Responsible person: Administrator or designee, with Monument Health or another qualified healthcare provider.<br>Target completion date for outstanding screenings: No later than October 30, 2026; sooner if arrangements permit.<br>Future screenings: Within the timeframe specified in the administrative rule.<br>Ongoing monitoring: Monthly and permanent, with weekly tracking of pending screenings. | 10/10/26 |

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| S 331 | Continued From page 16<br>TB skin test or blood assay within twenty-one days of their hire date.<br><br>Findings include:<br><br>1. Review of employee C's personnel file revealed was hired on 3/21/26 as a certified medication aide (CMA) and cook. Her file contained a copy of a two-step TB skin test completed at a previous employer in 2023. There was no documentation that a TB screening and test was completed within twenty-one days of her 3/21/26 hire date.<br><br>2. Review of employee D's personnel file revealed she was hired on 5/15/26 as a personal care aide (PCA). There was no documentation in her file that a TB screening and test was completed.<br><br>3. Interview on 8/26/26 at 9:45 a.m. with owner/administrator/CMA A revealed that employees C and D did not have a TB screening and test completed within twenty-one days of their hire dates, and this should have been done. She acknowledged that the employee files needed improvement, including making sure the evaluations and screenings were completed in a timely manner.<br><br>4. Review of the provider's undated Tuberculosis (TB) Prevention, Screening, and Exposure Response policy revealed, "Before or at placement into resident-contact duties - and not later than 21 days after employment begins - complete a baseline individual TB risk assessment, TB symptom screen, and an approved test unless a documented exception applies." | S 331 | | |

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| S 337 | Continued From page 17 | S 337 | S337 — Care Policies | |
| S 337 | 44:70:04:11 Care Policies<br><br>Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, manufacturer's recommendations, and policy review, the provider failed to ensure professional standards of practice were followed regarding the disposal of used needles, that resident medications were stored in a secured refrigerator, and that insulin pen preparation and administration for one of one sampled resident (2) by one of one observed administrator/owner/certified medication aide (CMA) (A) was completed.<br><br>Findings include:<br><br>1. Observation and interview on 8/26/26 at 7:57 a.m. with administrator/owner/CMA A during resident 2' medication administration revealed administrator/owner/CMA A assembled the glucometer and finger lancet (a small, sharp tool with a pointed blade or needle used to make tiny cuts or prick the skin). She then went to the dining room table where resident 2 was sitting and handed resident 2 the supplies. He performed a finger stick and his blood glucose reading was 132. She returned to the kitchen. She took an empty one-gallon milk carton from the cupboard, removed the lid to the milk carton, and placed the used lancet into it. The outside of the milk carton had "SHARPS" written with a | S 337 | The identified sharps disposal, medication refrigerator security, and insulin-pen preparation and dating concerns were corrected on August 26, 2026, during the survey.<br><br>Approved sharps containers replaced milk cartons for disposal of used needles and lancets. The medication refrigerator was secured against unauthorized access. Insulin-pen preparation was corrected to follow the specific manufacturer's instructions, including required safety testing or priming and documentation of the opening date.<br><br>The Administrator and RN will review all medication-storage areas, sharps containers, and medications requiring opening or discard dates to identify and correct similar concerns. Medication storage, insulin-pen use, and sharps handling will follow manufacturer instructions and accepted professional practice.<br><br>The RN will review resident 2's insulin self-administration process and clarify the assistance staff are authorized to provide. Applicable personnel, including the Administrator, will receive instruction and demonstrate competency in medication security, insulin-pen preparation and dating, and safe sharps handling. Policies will be reviewed and updated as needed.<br><br>The Administrator or designee will check medication security and sharps containers daily. The RN will observe applicable practices weekly for four weeks, then monthly on a permanent, ongoing basis. Findings, corrective actions, additional training, and follow-up will be documented.<br><br>Responsible person: Administrator and RN.<br>Immediate corrective actions completed: August 26, 2026, during the survey.<br>Ongoing monitoring and education: Permanent. | 8/26/26 |

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|---|---|---|---|---|
| S 337 | Continued From page 18 | S 337 | | |

black permanent marker. Administrator/owner/CMA A stated the staff used the milk carton as their used sharps destruction container. After the milk carton was full they brought it to the Veteran's Administration pharmacy to be destroyed.

2. Observation and interview on 8/26/26 at 8:02 a.m. with administrator/owner/CMA A revealed there was a small refrigerator in the kitchen on the counter by the sink. Administrator/owner/CMA A opened the door to the refrigerator and removed the Glargine Flexpen (a long-acting insulin used once daily to control blood sugar levels in people with diabetes) from the unlocked refrigerator. She dialed the insulin pen to 15 units. Handed the insulin pen to the surveyor to verify she had dialed the insulin pen to 15 units. The date the pen was opened was not documented on the pen. Administrator/owner/CMA A did not prime the pen before handing the insulin pen to resident 2. She then went to the dining room table and handed the insulin pen to resident 2. Resident 2 self-administered the insulin. She had resident 2 place a cap over the needle, and then the cover. She returned to the kitchen and disposed of the used needle into the milk carton.

3. Administrator/owner/CMA A confirmed the refrigerator where resident 2's insulin was stored was not locked. She did not prime the insulin pen by wasting two units of insulin before administering the allotted amount of insulin from the pen, and should have. She confirmed there was not a date on the insulin pen when it was opened, and there should have been. The facility "probably" should have used an official Sharps container for the destruction of used needles.

4. Review of the manufacturer's label inside of

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| S 337 | Continued From page 19<br>the Glargine Flexpen box revealed "Do a safety test. Select 2 units, press button all the way in, when insulin comes out of the needle tip, your pen is working correctly."<br><br>Review of the provider's undated Medication Administration policy revealed "29. Facility-controlled medications are inaccessible to residents, visitors, children, and unauthorized staff and remain in a locked room, cabinet, cart, or refrigerator except during an attended medication pass." | S 337 | | |
| S 443 | 44:70:05:07 Care Of A Resident With Cognitive Impairment<br><br>Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on care record review, interview, and policy review, the provider failed to ensure two of four sampled residents (5 and 6) had an annual cognitive screening completed.<br><br>Findings include:<br><br>1. Review of resident 5's care record revealed he admitted to the facility on 4/27/14. His last annual cognitive screening was completed on 1/13/25. There was no documentation to support any further annual screenings were completed.<br><br>2. Review of resident 6's care record revealed he admitted to the facility on 3/28/25. His last annual cognitive screening was completed on 3/2/25. | S 443 | S443 — Care of a Resident With Cognitive Impairment<br><br>The new facility nurse is currently working to obtain updated cognitive screenings for residents 5 and 6 and any other residents with missing or overdue screenings. Corrections will be completed by October 15, 2026. Screening will use a validated tool administered by appropriately trained personnel. Actual screening dates and results will be documented in each resident's care record.<br><br>The nurse will review all current resident records to verify that cognitive screenings are current. Results will be reviewed and incorporated into care planning, with healthcare provider notification and further evaluation as indicated.<br><br>The resident evaluation policy and tracking system will specify cognitive screening upon admission, yearly, and after a significant change in condition. The tracking log will identify each resident's most recent screening date, next due date, and the person responsible for completion.<br><br>Staff will receive instruction on recognizing and promptly reporting changes in cognition. The Administrator will arrange qualified backup personnel if the assigned screening professional is unavailable.<br><br>The Administrator and facility nurse will review outstanding screenings weekly until complete and review the tracking log monthly thereafter on a permanent, ongoing basis. Findings, follow-up, and corrective actions will be documented.<br><br>Responsible person: Administrator and facility nurse.<br>Target correction completion date: October 15, 2026.<br>Ongoing monitoring: Monthly and permanent, with screening upon admission, yearly, and after a significant change in condition. | 10/01/26 |

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| S 443 | Continued From page 20<br>There was no further documentation to support annual screenings were completed.<br><br>3. Interview on 8/25/26 at 4:02 p.m. with owner/administrator/certified medication aide A regarding cognitive screening expectations revealed the residents' annual cognitive screenings should have been completed. Registered nurse (RN) G had recently resigned but was assisting them until a new nurse was hired. RN G had told her she was behind with the cognitive screenings. RN G was responsible for ensuring the cognitive screenings were completed, but did not complete them for residents 5 and 6 and should have.<br><br>4. Review of the provider's undated Evaluation of Resident Needs policy revealed "Every resident will receive a person-centered, accurate, and sufficiently comprehensive evaluation completed at the location." Required evaluation domains include cognition/executive function. | S 443 | | |
| S 506 | 44:70:06:17 Required Dietary Inservice Training<br><br>The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects:<br><br>(1) Food safety;<br>(2) Handwashing;<br>(3) Food handling and preparation techniques;<br>(4) Food-borne illnesses;<br>(5) Serving and distribution procedures;<br>(6) Leftover food handling policies; | S 506 | | |

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| S 506 | Continued From page 21<br><br>(7) Time and temperature controls for food preparation and service;<br>(8) Nutrition and hydration; and<br>(9) Sanitation requirements.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on personnel file review, interview, and annual training curriculum review, the provider failed to ensure four of six sampled employees (A, B, E, and F) had received annual dietary training and that two of six newly hired employees (C and D) had received initial dietary training on the required training topics of food safety, handwashing, food handling/preparation, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.<br><br>Findings include:<br><br>1. Review of employee A's personnel file revealed she was hired on 9/8/22 as the owner/administrator/certified medication aide (CMA). There was no documentation that she completed annual training on the required dietary topics.<br><br>2. Review of employee B's personnel file revealed she was hired on 11/24/23 as a CMA. There was no documentation that she completed annual training on the required dietary topics.<br><br>3. Review of employee C's personnel file revealed she was hired on 3/21/26 as a CMA and | S 506 | S506 — Required Dietary Inservice Training<br><br>All personnel providing dietary or food-handling services, including employees A through F, completed training on all nine required dietary subjects by September 12, 2026.<br><br>Training covered food safety; handwashing; food handling and preparation techniques; foodborne illnesses; serving and distribution procedures; leftover food handling policies; time and temperature controls for food preparation and service; nutrition and hydration; and sanitation requirements.<br><br>The person in charge of dietary services or a dietitian will provide ongoing dietary education. The onboarding checklist and annual education schedule will require completion of all nine subjects within thirty days of hire and annually thereafter. Dietary education will remain part of the facility's permanent monthly staff education program.<br><br>Individual training records and a master tracking log will identify subjects covered, actual completion dates, instructor, attendance, and next due dates. Staff understanding will be verified through discussion, observation, or competency checks as appropriate.<br><br>The Administrator or designee will review dietary training records monthly and observe food-handling practices weekly on a permanent, ongoing basis. Missing documentation will receive prompt follow-up. Unsafe practices will be corrected immediately, with additional instruction and documented follow-up.<br>Policies were reviewed 10/01/26<br><br>Responsible person: Administrator and person in charge of dietary services or dietitian.<br>Training and correction completed: September 12, 2026.<br>Ongoing education and record review: Monthly and permanent.<br>Food-handling observations: Weekly and permanent. | 9/12/26 |

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| S 506 | Continued From page 22<br>cook. There was no documentation that she had completed training within thirty days of her hire date on the required dietary topics.<br><br>4. Review of employee D's personnel file revealed she was hired on 5/15/26 as a personal care aide (PCA). There was no documentation that she had completed training within thirty days of her hire date on the required dietary topics.<br><br>5. Review of employee E's personnel file revealed she was hired on 7/6/23 as a PCA. There was no documentation that she completed annual training on the required dietary topics.<br><br>6. Review of employee F's personnel file revealed was hired on 9/8/22 as the bookkeeper/CMA. There was no documentation that he completed annual training on the required dietary topics.<br><br>7. Interview on 8/26/26 at 9:45 a.m. with owner/administrator/CMA A revealed that all employees assisted with preparing and serving meals to the residents. The facility did not have a formalized dietary training program and employees were provided guidance and instruction within their workday.<br><br>8. Review of the provider's undated annual training curriculum revealed that it did not address dietary training on the required topics. | S 506 | | |
| S 680 | 44:70:07:08 Medication Records And Administration<br><br>A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse | S 680 | | |

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| S 680 | Continued From page 23<br>practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, care record review, interview, and policy review, the provider failed to ensure medications were documented after they were administered by one of one observed certified medication aide (CMA) (B) for six of six sampled residents (1, 4, 5, 7, 8, and 9).<br><br>Findings include:<br><br>1. Observation on 8/25/26 from 12:03 p.m. through 12:16 p.m. with CMA B during medication administration revealed at 12:03 p.m. she prepared resident 7's medications. She signed her initials on his medication administration record (MAR) indicating she had administered the medications. She then administered his medications to him.<br><br>At 12:05 p.m., CMA B prepared resident 8's medications. She signed her initials on his MAR indicating she had administered the medications. She then administered his medications to him.<br><br>At 12:07 p.m., CMA B prepared resident 1's medications. She signed her initials on his MAR indicating she had administered the medications. She then administered his medications to him.<br><br>At 12:09 p.m., CMA B prepared resident 4's | S 680 | S680 — Medication Records and Administration<br><br>Employee B and all personnel who administer medications will receive instruction on documenting medication administration immediately after the resident takes or receives the medication. Staff will not sign or initial the medication administration record (MAR) before administration. Refused, held, or omitted doses will be documented accurately according to facility policy.<br><br>The RN will review medication administration and documentation practices for residents 1, 4, 5, 7, 8, and 9, as well as all other residents receiving staff-administered medications. MARs will be checked against current prescriber orders. Identified discrepancies will be investigated and addressed through appropriate notification and record-correction procedures.<br><br>The medication administration policy will be reviewed with all applicable staff. Each person who administers medications, including the Administrator when performing this duty, will demonstrate through direct observation that documentation occurs after administration.<br><br>The RN will directly observe each medication-administration staff member weekly for four weeks following retraining and monthly thereafter on a permanent, ongoing basis. Monitoring will include direct observation because MAR review alone cannot establish whether staff signed before or after administration.<br><br>Findings, corrective actions, competency checks, and additional instruction will be documented. Medication documentation education will remain part of orientation and the ongoing monthly staff education program.<br><br>Responsible persons: Administrator and RN.<br>Correction and training completion dates:<br>Completed the day after the survey and repeated on September 12.<br>Ongoing monitoring and education: Permanent. | 09/12/26 |

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| S 680 | Continued From page 24<br>medications. She signed her initials on his MAR indicating she had administered the medications. She then administered his medications to him.<br><br>At 12:13 p.m., CMA B prepared resident 5's medications. She signed her initials on his MAR indicating she had administered the medications. She then administered his medications to him.<br><br>At 12:16 p.m., CMA B prepared resident 9's medications. She signed her initials on his MAR indicating she had administered the medications. She then administered his medications to him.<br><br>2. Interview on 8/25/26 at 12:18 p.m. with CMA B confirmed she had signed resident 1, 4, 5, 7, 8, and 9's MARs before administering each resident's medications.<br><br>3. Interview on 8/26/26 at 8:15 a.m. with owner/administrator/CMA A regarding the above observations revealed registered nurse (RN) G had trained the CMAs to document with their initials on the MARs prior to administering the medications. She agreed the medications should be documented after each resident has taken their medications.<br><br>4. Review of the provider's undated Medication Administration policy revealed "28. Each administration is documented immediately after the resident takes/receives the dose. 65. Activate needle safety features and place sharps immediately--without recapping, bending, or hand removal--into an approved, closable , puncture-resistant sharps container." | S 680 | | |
| S 685 | 44:70:07:09 Self-Administration of Medications | S 685 | | |

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| S 685 | Continued From page 25<br>A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications.<br>The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter.<br>Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on care record review, interview, and policy review, the facility failed to ensure one of one sampled resident (2) who self-administered his medications was evaluated quarterly to ensure he was able to administer his medications safely.<br><br>Findings include:<br><br>1. Review of resident 2's care record revealed that he admitted to the facility on 12/1/25. His diagnosis included diabetes mellitus (a condition in which disruptions in how the body regulates blood sugar). The physician's order indicated to administer 15 units of Glargine daily in the morning. His 8/1/26 through 8/25/26 medication administration record indicated he had received | S 685 | S685 — Self-Administration of Medications<br><br>Resident 2's self-administration assessment was completed at Fort Meade VA before discharge. The facility will obtain documentation of that assessment by October 15, 2026. The facility RN will complete and document another self-administration assessment by the same date.<br><br>An order authorizing self-administration will be obtained from the resident's physician, physician assistant, or nurse practitioner before continued self-administration. Until the required assessment documentation and authorization are verified, qualified staff will administer the medication according to current prescriber orders.<br><br>The assessment will identify whether the resident or healthcare personnel is responsible for medication storage and how administration will be documented. Resident 2's service plan and medication records will be updated to reflect these responsibilities.<br><br>The RN will review all residents who self-administer medications or store medications in their rooms to verify that each has a documented assessment, an appropriate prescriber order, and clearly assigned storage and documentation responsibilities. Identified deficiencies will be corrected.<br><br>The self-administration policy will be reviewed with applicable staff, including the Administrator. Education will address assessment before self-administration begins, required prescriber authorization, storage responsibilities, administration documentation, and reassessment requirements. A cognitive screening score alone will not replace a self-administration assessment.<br><br>The RN will determine and document the continued appropriateness of each resident's ability to self-administer medications at least every three months and sooner when changes raise concerns about safe self-administration. The Administrator and RN will maintain a tracking system for reassessment due dates and review it monthly on a permanent, ongoing basis.<br><br>Assessments, orders, service-plan updates, monitoring findings, corrective actions, and staff education will be documented. Self-administration requirements will remain part of orientation and ongoing staff education.<br><br>Responsible persons: Administrator and RN.<br>Assessment documentation and facility RN reassessment completion date: October 15, 2026.<br>Ongoing monitoring and education: Permanent. | 10/01/26 |

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| S 685 | Continued From page 26<br>15 units of Glargine every morning.<br><br>His 12/3/25 mini-mental status evaluation score was 30 out of 30 points, which indicated his cognition was intact. There was no documentation that a self-administration of medication assessment was completed. There was no physician's order indicating he could self-administer his own insulin. The undated service plan stated "AM [a.m.] injection - insulin."<br><br>2. Interview on 8/25/26 at 4:05 p.m. with administrator/owner/certified medication aide A regarding resident 2 revealed he self-administered his insulin. A self-administration of medication assessment was never completed by the registered nurse (RN) G, and it should have been.<br><br>3. Review of the provider's undated Self-Administration of Medications policy revealed the purpose was "to preserve resident independence while ensuring that self-administration of medications occurs only when it has been determined safe, ordered when required, clearly assigned, properly stored, documented, monitored, and reassessed."<br>"1. A registered or licensed nurse, physician, physician assistant, nurse practitioner, or other appropriate practitioner authorized by the applicable rule must determine and document that self-administration is safe." "Before self-administration begins, the evaluating professional will assess and record whether the resident can consistently" self-administer medications. The facility "will use a minimum three-month reassessment standard. A qualified nurse or practitioner will evaluate and record continued appropriateness at least every three months and sooner." | S 685 | | |

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