| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10767 | A. BUILDING: _____ B. WING _____ | C 07/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHMARK AT ALL SAINTS | 111 WEST 17TH STREET SIOUX FALLS, SD 57104 |

| (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<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 7/14/26 through 7/15/26. Areas surveyed included physical environment/elopement, nursing services, pharmaceutical services, potential for resident neglect, quality of life, administration/personnel, and educational services. Touchmark at All Saints was found not in compliance with the following regulation: S836. | S 000 | | |
| S 836 | 44:70:09:09(2) Quality Of Life<br><br>A facility shall provide care and an environment that contributes to the resident's quality of life, including:<br><br>(2) Maintenance or enhancement of the resident's ability to preserve individuality, exercise self-determination, and control everyday physical needs;<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, care record review, and policy review, the provider failed to ensure resources (water) were available for one of one sampled resident (6) to provide herself with personal care that contributed to her quality of life in the Pembrook care unit (a secure memory care unit).<br><br>Findings include: | S 836 | S836<br><br>Plan of Correction<br>1. Corrective Action for the Identified Resident and Other Potentially Affected Residents:<br>Water service to Resident #6's bathroom sink was immediately restored. The resident's service plan was updated to address behaviors that contributed to flooding while maintaining access to running water for hygiene. Memory care staff were educated on the revised care plan, proper use of the sink shut-off key, and the requirement that residents maintain access to running water unless an approved, documented alternative intervention is in place. | 8.15.2026 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 7/30/2026

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10767 | A. BUILDING: _____ B. WING _____ | C 07/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHMARK AT ALL SAINTS | 111 WEST 17TH STREET SIOUX FALLS, SD 57104 |

| (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 836 | Continued From page 1<br><br>1. Observation on 7/14/26 at 11:53 a.m. in resident 6's room revealed she was in her bathroom staring at the closed lid of the toilet seat, which had bowel movement (BM) smeared on the back portion of it. She took a piece of toilet tissue and bent over and picked up a round walnut-sized piece of BM from the floor. She squished the fecal matter between her fingers and then laid the toilet tissue with the BM on the sink counter. She had mumbled incoherent words during the observation.<br><br>The surveyor left the room and informed caregiver C about the above observation. Caregiver C escorted resident 6 out of her room and to a sink at the end of the lounge area and instructed her to wash her hands. Resident 6 then performed hand hygiene.<br><br>2. Interview on 7/14/26 at 11:57 a.m. with caregiver C regarding the above observation of resident 6 revealed that the water was turned off to her bathroom sink because she had left the water running in her bathroom, causing flooding to her room and extending out of her room into the dining room a few times. She was constantly washing her hands and would forget to shut the water off. Resident 6 would sometimes sit on the toilet, put her hands into her brief, and pull out small pebble-sized pieces of BM. She would leave her room and touch the walls and furniture outside of her room with her soiled hands. The facility had decided to turn the water off to her sink as an intervention to stop the flooding of water. Resident 6 did not have water to her bathroom sink up to 4 to 5 months.<br><br>The surveyor asked caregiver C how resident 6 completed her personal care, and she responded that when she assisted resident 6 she would have | S 836 | S 836<br><br>2. System Changes to Achieve Sustained Compliance<br>The facility has implemented the following system changes:<br>• A policy will be implemented requiring interdisciplinary review, approval, documentation, and staff communication before any intervention that limits a resident's access to personal care resources, including running water. All nursing staff, medication aides, caregivers, and applicable department staff will receive education on resident rights, individualized care planning, infection prevention, and maintaining access to resources necessary for personal hygiene.<br>• An audit of all resident rooms in the memory care neighborhood was completed to identify any resident whose sink water had been turned off or whose access to water may have been limited. Any identified concerns were immediately corrected, and applicable service plans were reviewed and updated to reflect individualized interventions.<br><br>3. Monitoring to Prevent Future Noncompliance<br>• Any environmental interventions needed will be reviewed by our interdisciplinary team during our quality assurance meetings quarterly<br>4. Anticipated Completion Date<br>August 15, 2026<br><br>The deficient practice was immediately corrected during the survey by restoring water service to Resident #6's bathroom sink. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10767 | A. BUILDING: _____ B. WING _____ | C 07/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHMARK AT ALL SAINTS | 111 WEST 17TH STREET SIOUX FALLS, SD 57104 |

| (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 836 | Continued From page 2 | S 836 | | |

resident 6 go to her bathroom. The water still worked in the shower, so she would run hot water from the shower over a washcloth so resident 6 could wash her face. Then she would fill a glass with cold water from the shower, put it on the sink counter for resident 6 to use while brushing her teeth. Caregiver C knew there was a key to the sink to turn the water off and on but was not sure who had the key.

3. Interview on 7/14/26 at 1:00 p.m. with clinical care manager/licensed practical nurse (LPN) A and health services director/LPN B regarding the above observation with resident 6 revealed they agreed there should have been water available in her bathroom to wash her hands. There was a key that staff should have to turn the water off and on with, and the building service director had the key.

4. Interview on 7/14/26 at 1:45 p.m. with clinical care manager/LPN A and health services director/LPN B revealed the certified medication aide (CMA) on the unit had a key on her key ring to turn the sink water on and off. The CMA was aware of the key, but caregiver C was not aware and should have been. They turned the water back on in resident 6's bathroom during the survey. They had instructed the staff to do checks/monitor resident 6's bathroom in her service plan.

5. Review of resident 6's care record revealed she admitted to the facility on 12/4/24. Her diagnoses included dementia with behavior disturbance, fecal incontinence, rectal prolapse, sigmoid diverticulosis, colon polyps, and hemorrhoids. The 4/14/26 service plan for resident 6 indicated she needed full staff assistance with bathing, assistance with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10767 | A. BUILDING: _____ B. WING _____ | C 07/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOUCHMARK AT ALL SAINTS | 111 WEST 17TH STREET SIOUX FALLS, SD 57104 |

| (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 836 | Continued From page 3<br>grooming, oral care, dressing, and toileting. "Staff will provide continence checks every two to three hours." The 12/26/25 Mini-Cog (assessment tool for screening for cognition) score was 0 out of 5 points, which indicated her cognition was severely impaired.<br><br>6. Interview on 7/15/26 at 11:30 a.m. with health services director/LPN B confirmed resident 6's service plan did not contain information regarding the water to her sink was turned off and should have.<br><br>7. Review of the provider's undated Dementia Care Philosophy policy stated "Dignity: Residents shall always be treated with respect regardless of cognitive impairment. Team members shall preserve resident rights during all interactions." | S 836 | | |