

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41968	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/28/2026
NAME OF PROVIDER OR SUPPLIER SILVER THREADS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 12TH ST GREGORY, SD 57533			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 7/27/26 through 7/28/26. Silver Threads Inc was found not in compliance with the following requirements: S169, S201, S295, S506, S640, and S685. 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 7/27/26 through 7/28/26. The area surveyed included a resident who had two unwitnessed falls. Silver Threads Inc was found in compliance.	S 000			
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to install a door alarm system that was continuous and did not self-silence. Findings include:	S 169	Plan of Correction – 44:70:02:05 Door Alarm Requirements (S169) The facility submits the following Plan of Correction in response to the citation regarding failure to install and maintain an electrically activated alarm system that is continuous, audible at a designated staff station, and does not self-silence when the door is closed. 1. Corrective Actions Taken & Identification of Other Potentially Affected Residents. Following the survey on 7/28/26, the facility immediately evaluated the alarm system on all exterior doors. Testing confirmed that the existing pager-based alarm system chimed three times and then self-silenced, resulting in staff not responding to door openings. The facility has purchased six new door transmitters that have a chain included to ensure the connection is reestablished prior to resetting. All residents were considered potentially affected due to possibility of an undetected exit. To ensure safety, every exterior door was inspected and tested. Staff were instructed to maintain heightened observation until the new alarm transmitters are fully installed and tested. 2. Systemic Changes to Achieve Sustained Compliance The door alarm transmitters will be replaced with a required manual reset rather than simply closing the door. Staff will be required to physically walk to the door and reset the chain to ensure activation of the transmitter.	9/10/26	

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

[Signature]

TITLE

Administrator

(X6) DATE

8-20-26

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S 169	Continued From page 1 1. Observation and testing on 7/28/26 from 10:00 a.m. to 2:00 p.m. revealed that all care staff wore pagers. Testing of the alarms on each door revealed an alarm triggered on the pagers when the doors were opened. The staff did not respond to the door alarms. They continued with their tasks. 2. Interview on 7/28/26 at 1:00 p.m. with staff members C, D, E, F, and the administrator A revealed the door alarms chimed on the pagers three times, then went silent. 3. Interview and testing on 7/28/26 at 1:15 p.m. of the front door alarm with administrator A revealed the door alarm chimed three times on his pager, then went silent. He had started working at the facility on 4/1/26, as part of new ownership. The door alarms were self-silencing prior to him becoming administrator. They had identified that the staff were not responding to door alarms and were in the process of retraining the staff. He agreed that the doors were self-silencing.	S 169	3. Monitoring to Identify Future Noncompliance Data to be Monitored: -Monthly exterior door alarm testing logs -Maintenance work orders related to alarm systems. Who will Perform the Monitoring: -Director of Maintenance will conduct and document monthly alarm testing. -Administrator will review all logs, incident reports, and maintenance records. Frequency and Duration: -Exterior door alarms will be tested monthly for six months. Integration into the QA System: -The Director of Maintenance will submit monthly alarm testing results to the Administrator. -The Administrator will report findings to the Quality Assurance Committee at the monthly QA meeting indefinitely. -Any identified deficiencies will result in immediate corrective action, retraining, and documentation in the QA minutes. 4. Anticipated Date of Correction: September 10, 2026	
S 201	44:70:03:02 General Fire Safety 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. This Administrative Rule of South Dakota is not	S 201	Plan of Correction - 44:70:03:02 General Fire Safety The facility submits the following Plan of Correction in response to the citation regarding failure to maintain one of the four emergency exits clearly marked, unobstructed, and accessible to residents in accordance with fire safety requirements. 1. Correction Action Taken & Identification of Other Potentially Affected Residents. Following the survey on 7/28/26, the facility evaluated the east exit leading to the independent apartments and garage. The exit was found to be locked, unmarked, and inaccessible without knowledge of a keypad code. The garage door opener was located above the door frame, unmarked, and not easily reachable. The exterior walk-through door between the apartments and garage was also locked and required a code.	9/1/26

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SILVER THREADS INC

210 E 12TH ST
GREGORY, SD 57533

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S 201	Continued From page 2 met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain one of four emergency exits (east exit by the independent apartments) clearly marked and free from obstruction. Findings include: 1. Observation and testing on 7/28/26 at 2:00 p.m. revealed the east exit to the independent apartments was locked. Assisted living residents could not exit into the independent apartments without knowing the exit door's code. There was an exit sign posted on the walk-through door leading into the garage. The only way to exit from the garage was to open the garage door, as there was no exterior walk-through door. The button to open the garage door was located above the door frame and was not easily accessible or marked. Between the door leading into the independent apartments and the garage door was an exterior walk-through door. That door was also locked and could not be opened without knowledge of the door's code. 2. Interview on 7/28/26 at 2:00 p.m. with administrator A revealed he had become administrator on 4/1/26, as part of a change in ownership. He was not aware of the exit into the garage, as he did not use that exit since he had started working at the facility. The staff used the exterior walk-through door to come and go from the facility. He agreed the exterior walk-through door should be marked as an exit and unlocked from the inside so the residents could leave in the event of an emergency.	S 201	Corrective actions included: -The east exit door was unlocked from the inside to allow free egress for assisted living residents during emergencies. -Proper exit signage was installed above the exterior walk-through door. -Staff were instructed on the corrected exit route and the importance of maintaining all exits unobstructed and accessible. All residents were considered potentially affected due to the possibility of delayed evacuation. As a result, all facility exits were inspected to ensure they were unlocked from the inside, clearly marked, and free of obstruction. No additional exit issues were identified. 2. Systemic Changes to Achieve Sustained Compliance To ensure sustained compliance with fire safety regulations, the facility implemented the following systemic changes: -Updated the Emergency Exit and Fire Safety Policy to require that all emergency exits were updated and marked appropriately. -Conducted retraining for all staff on: -Emergency exit locations -Proper use of exit routes -Immediate reporting of any blocked, locked, or malfunctioning exit -Administrator orientation procedures were updated to ensure new leadership receives a full walkthrough of all exit routes and emergency egress pathways. 3. Monitoring to Identify Future Noncompliance Date to be monitored: -Fire drill documentation, which is completed monthly. Who Will Perform the Monitoring: -Director of Maintenance will complete and document monthly exit inspections. -Administrator will review all exit inspection logs, fire drill records, and maintenance reports. Frequency and Duration: -Fire drills and exit inspections will be conducted during the monthly drills that are completed by the Director of Maintenance. Integration into the QA System: -The Administrator will present findings to the Quality Assurance Committee at the monthly QA meeting for twelve months. -Any identified deficiencies will result in immediate corrective action, retraining, and documentation in QA minutes. 4. Anticipated Date of Correction: September 1, 2026	

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S 296	Continued From page 3	S 296	Plan of Correction - 44:70:04:04 Personnel Training Requirements	8/31/26
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies 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 (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. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by:	S 296	The facility submits the following Plan of Correction in response to the citation regarding failure to ensure newly hired employee D received personnel training within 30 days of hire. 1. Corrective Action Taken & Identification of Other Potentially Affected Staff Upon identification of the deficiency on 7/28/26, the Administrator immediately reviewed employee D's personnel file and confirmed that required training modules - including infection control, accident prevention and safety procedures, confidentiality, mandatory reporting, and abuse/neglect/ misappropriation - had not been assigned or completed within 30 days of hire date (12/29/25). Corrective actions included: --Employee D was immediately assigned and completed all missing training modules. --Documentation of completion was added to her personnel file. --The administrator conducted a full audit of all personnel files for employees hired within the past 12 months to identify any other potentially affected staff. --Two additional employees were identified as having incomplete training documentation; both were assigned and completed all required modules, and their files were updated accordingly. 2. Systemic Changes to Achieve Sustained Compliance To ensure sustained compliance with personnel training requirements, the facility implemented the following systemic changes: --Updated the New Hire Training Assignment Procedure to ensure that all required modules be assigned and completed prior to employee's first day of employment. --Ensured that the New Hire Training Checklist was being utilized. 3. Monitoring to Identify Future Noncompliance Date to be monitored: --Educare training status will be monitored for completion prior to official start date. Who will Perform the Monitoring: --Administrator will review training completion reports prior to scheduling any new employees.	

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S 296	Continued From page 4 Based on employee personnel file review and interview, the provider failed to ensure one of five newly hired employees (D) reviewed had received training in the areas of infection control and prevention, accident prevention and safety procedures, confidentiality, incidents and diseases subject to mandatory reporting and the facility's reporting mechanism, and abuse, neglect, and misappropriation of resident property and funds within 30 days of her hire date. Findings include: 1. Review of the personnel file for employee D revealed she was hired as a cook on 12/29/25. There was no documentation to support that she had completed training in the areas of infection control and prevention, accident prevention and safety procedures, confidentiality, incidents and diseases subject to mandatory reporting and the facility's reporting mechanism, and abuse, neglect, and misappropriation of resident property and funds. 2. Interview on 7/28/26 at 10:42 a.m. with administrator A regarding staff education revealed that employee D was not assigned the training courses upon her hire date. He was responsible for ensuring the training was completed.	S 296	Frequency and Duration: -New hire education status will be monitored by administration for completion. No employee will be allowed to start their employment on the floor until training has been completed. Integration into the QA System: -The Administrator will monitor and report training results to the Quality Assurance Committee at the monthly QA meetings. -Any identified deficiencies will result in immediate corrective action, retraining, and documentation in QA minutes. 4. Anticipated Date of Correction: August 31, 2026	8/20/26	
S 337	44:70:04:11 Care Policies 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.	S 337	Plan of Correction - 44:70:04:11 Care Policies The facility submits the following Plan of Correction in response to the citation regarding failure to ensure resident 1 received medication that was tablet-split by pharmacist, in accordance with accepted standards of professional practice and facility policy.		

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S 337	Continued From page 5 This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) received medication that was tablet-split by the pharmacist. Findings include: 1. Review of resident 1's care record revealed her admission date was 6/15/23. Her diagnoses included a cerebrovascular accident and chronic diastolic congestive heart failure. Resident 1's physician's orders included a 6/15/23 order for 100 milligrams (mg) of Losartan Potassium, to take one tablet by mouth daily at 8:00 a.m. The order included a note to the pharmacy to split the tablet in half and put the two halves in each medication slot. Review of resident 1's nursing notes indicated that on 6/22/25, "Resident has been complaining of having difficulty swallowing her medication Losartan. Pharmacist, [redacted name], called and visited with [the] resident to inform her that this medication does not come in a coated form. It was decided that [the] resident would be able to take the medication if the pill was cut in half. Pharmacist approved this and [the] medication with [will] be in two halves in [the] next bubble pack. For the remainder of this month, UAPs [unlicensed assistive personnel] may split the medication in half so [the] resident is able to take [it]. This was relayed to [redacted name], UAP on duty today." 2. Interview on 7/28/26 at 1:10 p.m. with UAP C revealed that when a resident received a physician's order for a medication, the order	S 337	1. Corrective Action Taken & Identification of Other Potentially Affected Residents Following the identification of the deficiency on 7/28/26, the Director of Nursing (DON) immediately reviewed resident 1's medication orders and bubble packs. It was confirmed that staff had been splitting Losartan tablets prior to administration, despite the physician order specifying that the pharmacy was to split the medication and provide it in two halves. Corrective actions included: - Resident 1's Losartan bubble pack was removed from use and returned to the pharmacy. - The pharmacy provided a new bubble pack with tablets pre-split according to the physician's order. - Staff were instructed that tablet-splitting is not permitted and is outside the scope of practice for both nurses and UAPs in an Assisted Living setting. - Resident 1's EMAR was reviewed to ensure the correct order was active and clearly documented. - All pill-splitters were removed from the facility. - Pharmacy was contacted and updated on Assisted Living Facility policies in regards to "no splitting of medication." To identify other potentially affected residents, the DON conducted a full audit of all residents receiving medications that may require tablet-splitting. No additional residents were found to have medications being split by staff. All bubble packs were verified to be pharmacy-prepared and compliant with physician orders. 2. Systemic Changes to Achieve Sustained Compliance To ensure sustained compliance with medication administration standards, the facility implemented the following systemic changes: - Updated the Medication Administration Policy to explicitly prohibit tablet-splitting by nurses or UAPs. - Added a section requiring that any medication requiring splitting must be prepared by the pharmacy and delivered in a compliant bubble pack.		

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S 337	Continued From page 6 showed up in the resident's electronic medication administration record (EMAR). She indicated that resident 1's Losartan medication order was changed sometime in June 2026 and that the staff were tablet-splitting that medication before administering it to resident 1. 3. Interview on 7/28/26 at 2:29 p.m. with director of nursing (DON) B regarding tablet-splitting residents medications revealed that when a physician ordered a change in resident's medication and the medication in the residents' bubble pack was the wrong, the new physician's order would be sent to the pharmacy. The new physician's order would be placed in the residents EMAR, and the resident's inaccurate bubble pack of medication would be pulled out of the medication cart and placed in the medication destruction box. The pharmacy would then send a new bubble pack with the correct medication. DON B approved all physician's orders in the resident's EMAR before the medications were administered to the residents. DON B was aware resident 1 was having trouble swallowing and stated that she was not aware the staff were tablet-splitting resident 1's Losartan medication order when it was changed. She stated that was not in the scope of practice for nurses or UAPs. DON B indicated that the uncut Losartan tablets should have been sent back to the pharmacy and a new bubble pack with tablets precut by the pharmacist should have been provided. 4. Review of the provider's undated Medication Administration policy revealed there was no directions for the splitting of medications by a UAP.	S 337	—Implemented a Medication Change Procedure requiring: —Immediate removal of inaccurate bubble packs —Documentation and removal and destruction —Verification of new bubble packs upon arrival —RN approval of all medication changes before administration —Educated all nursing and UAP staff on: —Scope of practice 3. Monitoring to Identify Future Noncompliance Date to Be Monitored: —Monthly medication cart audits —Monthly audits of any "Medication Administration Exceptions" —Incident reports related to medication administration Who Will Perform the Monitoring: —RN will perform monthly audits and report date to DON for modifications if necessary Frequency and Duration: —Monthly audits, indefinitely Integration into the QA System: —The DON will present monthly audit findings to the Administrator. —The Administrator will report results to the Quality Assurance Committee at the monthly QA meeting, indefinitely —Any discrepancies will result in immediate corrective action, retraining, and documentation in QA minutes. 4. Anticipated Date of Correction: August 20, 2026		

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S 506	Continued From page 7	S 506	Plan of Correction - 44:70:06:17 Required Dietary In-Service Training (S506)	8/20/26
S 506	44:70:06:17 Required Dietary Inservice Training 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: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel file review and interview the provider failed to ensure four of four newly hired employees (D, E, F, and G) reviewed had received training in the areas of food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, and sanitation requirements within 30 days of their hire date. Findings include: 1. Review of the personnel file for employee D	S 506 The facility submits the following Plan of Correction in response to the citation regarding failure to ensure newly hired dietary and food-handling personnel received required dietary in-service training within 30 days of hire and annually thereafter. 1. Corrective Action Taken and Identification of Other Potentially Affected Staff Following identification of the deficiency on 7/28/26, the Administrator reviewed personnel files for employees D, E, F, and G. It was confirmed that none had documentation of required dietary in-service training within 30 days of hire, and one employee (F) also lacked annual training documentation. Corrective actions included: -All four employees (D, E, F, and G) were immediately assigned and completed the required dietary in-service training modules covering: -Food safety -Handwashing -Food handling and preparation techniques -Food-borne illnesses -Serving and distribution procedures -Leftover food handling policies -Time and temperature controls -Nutrition and hydration -Sanitation requirements -Documentation of completion was added to each personnel file. To identify other potentially affected staff, the Administrator conducted a full audit of all personnel files for employees hire within the past 12 months. Two additional staff members were identified as missing annual dietary training documentation. Both were assigned and completed the required modules, and their files were updated accordingly. All staff who may handle food - including cooks, UAPs, RNs, and any personnel assisting with meal service - were considered potentially affected.		

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S 506	Continued From page 8 revealed she was hired as a cook on 12/29/25. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date. 2. Review of the personnel file for employee E revealed she was hired as a UAP on 1/8/26. There was no documentation to support that he had completed the dietary in-service training within 30 days of her hire date. 3. Review of the personnel file for employee F revealed she was hired as a UAP on 5/29/25. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date or annually. 4. Review of the personnel file for RN I revealed she was hired as a registered nurse (RN) on 12/8/25. There was no documentation to support that she had completed the dietary in-service training within 30 days of her hire date. 5. Interview on 7/28/26 at 10:38 a.m. with administrator A revealed he expected all employees to complete the required dietary training within 30 days of their hire date and annually. He was aware of the dietary in-service requirements, and confirmed that all of the staff members may handle food and should have had the education. Administrator A was unable to locate that any of the training for employees D, E, F, and G was completed.	S 506	2. Systemic Changes to Achieve Sustained Compliance To ensure sustained compliance with dietary in-service training requirements, the facility implemented the following systemic changes: --Updated the Dietary In-Service Training Policy to clearly outline: --Required training topics --Completion deadlines (within 30 days of hire and annually) --Documentation standards --Responsibility of the dietary manager/dietitian for providing and verifying training --Implemented a New Hire Training Checklist that must be completed and signed by the employee and initialed by office staff. --Added automated alerts in the training platform to notify the Administrator and dietary manager when: --Training is not completed within 15 days --Training is approaching the 30-day deadline --Annual training is due within 30 days --Required onboarding procedures to ensure all new staff who may handle food are automatically enrolled in dietary in-service modules on their first day. --Provided retraining to the Administrator and dietary manager proper assignment, tracking, and documentation of dietary training. 3. Monitor to Identify Future Noncompliance Date to Be Monitored: --New hire dietary training assignment logs --Dietary training completion reports --Personnel file documentation --Annual training compliance summaries Who Will Perform the Monitoring: --Dietary Manager will verify training assignment and completion for all new hires. --Administrator will conduct monthly personnel file audits. --Director of Nursing will review annual training compliance for all staff who assist with food service. Frequency and Duration: --Weekly monitoring of new hire dietary training completion for six months. --Monthly personnel file audits twelve months.	
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a	S 685		

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NAME OF PROVIDER OR SUPPLIER SILVER THREADS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 12TH ST GREGORY, SD 57533			
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S 685	Continued From page 9 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. 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. 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. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to ensure one of one resident (1) who self-administered physician-ordered eye wipes had a physician order to self-administer those wipes. Findings Include: 1. Review of resident 1's care record progress notes revealed that on 7/16/26 a nurse indicated "Did visit with resident regarding using OCUSOFT [pre-moistened pads to clean the eyelids and eyelashes] wipes and resident return[ed] demo that eye dr [doctor] told [her] and showed [her] how to use them and why she is doing it and [she] does it at night, noted [she] has [a] notebook at [her] bedside to chart herself when she does it." On 7/16/27, resident 1 signed "Rights and Responsibilities Associated With the Self-Administration of Medications". The	S 685	(S506 continued) --Quarterly review of annual dietary training compliance thereafter. Integration into the QA System: --The Dietary Manager will submit weekly and monthly monitoring results to the Administrator. --The Administrator will present findings to the Quality Assurance Committee at the monthly QA meeting for twelve months. --Any identified deficiencies will result in immediate corrective action, retraining, and documentation in QA minutes. --QA will track trends and ensure sustained compliance through ongoing review of dietary training completion date. 4. Anticipated Date of Correction: August 20, 2026 (S685) Plan of Correction - 44:70:07:09 Self-Administration of Medications The facility submits the following Plan of Correction in response to the citation regarding failure to ensure resident 1 had a physician's order authorizing self-administration of OCUSOFT eye wipes prior to beginning self-administration. 1. Corrective Action Taken & Identification of Other Potentially Affected Residents Following identification of the deficiency on 7/28/26, the Director of Nursing (DON) immediately reviewed resident 1's medication orders and self-administration documentation. It was confirmed that resident 1 began self-administering OCUSOFT wipes on 7/16/26, but the physician's order authorizing self-administration was not obtained until 7/27/26, eleven days later. Corrective actions included: --Resident 1's self-administration order was verified and placed in her record. --The DON completed a new self-administration assessment to confirm continued appropriateness of self-administration. --Staff were instructed that no resident may self-administer any medication without a physician's order explicitly authorizing self-administration. --Resident 1's self-administration documentation notebook was reviewed to ensure proper tracking and compliance.		8/15/26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41988	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/28/2026
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S 685	Continued From page 10 document included, "RN [registered nurse] and Physician and has been [have] determined that the practice is safe to both the Resident and others in the facility." Resident 1's 10/8/25 physician's order was for "OCUSOFT lid scrub pads to scrub both eye lids [eyelids] scheduled once each day" at 6:00 p.m. Her physician's order to self-administer medications was obtained on 7/27/26. This was 11 days after she had started to administer the OCUSOFT wipes herself. 2. Interview on 7/28/26 at 2:25 p.m. with director of nursing (DON) B regarding the resident's self-administration of medications revealed that the resident was required to have a physician's order before self-administering any medication. The physician's order should include which medications may be self-administered by the resident. The provider's nurse would complete an initial medication self-administration assessment to determine the resident's ability to safely self-administer medications and then obtain a physician's order for the resident to do so. DON B stated that resident 1 was supervised during her self-administration of the OCUSOFT wipes for eye washing and agreed a physician's order should have been obtained before allowing resident 1 to self-administer the OCUSOFT wipes. 3. Review of the provider's undated Self-Administration of Drugs (medications) policy revealed, "A Resident may self-administer medications if the registered nurse and physician have determined the practice to be safe."	S 685	To identify other potentially affected residents, the DON conducted a full audit of all residents who self-administer any medication or store medication in their rooms. No other residents were found to be self-administering medications without a valid physician's order. All self-administration assessments and orders were verified as current and compliant. 2. Systemic Changes to Achieve Sustained Compliance To ensure sustained compliance with self-administration requirements, the facility implemented the following systemic changes: - Ensured that the Self-Administration of Medication Policy included: - A requirement that a physician, PA, or NP order must be obtained prior to any self-administration. - A requirement that a registered nurse must complete the initial self-administration assessment before obtaining the order. - A requirement for quarterly reassessment of all residents who self-administer medications. - Clear documentation standards for storage responsibility administration tracking, and reassessment. 3. Monitoring to Identify Future Noncompliance Data to Be Monitored: - Self-administration assessments - Physician orders authorizing self-administration - EMAR documentation/self documentation - Quarterly reassessment logs - Incident reports related to medication administration Who Will Perform the Monitoring: - RN will conduct monthly audits of all self-administering residents. Frequency and Duration: - Monthly audits of all self-administration documentation - Quarterly reassessments Integration into the QA System: - The DON will present monthly audit findings to the Administrator. - The Administrator will report results to the Quality Assurance Committee at the monthly QA meeting for twelve months. - Any discrepancies will result in immediate corrective action, retraining, and documentation in QA minutes. 4. Anticipated Date of Correction: August 15, 2026	