South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41075	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HILLS ASSISTED LIVING 2	825 S 34TH ST SPEARFISH, SD 57783

(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 11/12/25 through 11/13/25. Garden Hills Assisted Living 2 was found not in compliance with the following requirements: S130, S200, S275, S280, S285, S315, S320, S352, S400, S432, S443, S450, S465, S474, and S782. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/12/25 through 11/13/25. Areas surveyed included potential resident abuse related to activities of daily living and potential verbal abuse from a staff member to a resident. Garden Hills Assisted Living 2 was found in compliance.	S 000		
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider was unsuccessful in following	S 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Dobson | TITLE: Administrator | (X6) DATE: 12/16/2025

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S 130	Continued From page 1 infection control procedures and practices by having failed to: *Assign a staff member to implement and oversee an infection control program. *Properly monitor and report infections. *Properly dispose of biohazardous sharps (needles and other sharp medical tools that could transmit diseases through blood or body fluids) containers (specialized containers designed to safely store and dispose of contaminated items with sharp edges). *Ensure appropriate glove use by two of two caregivers/certified medication aides (CMAs)/cooks (D and H) during medication administration. Findings include: 1. Observations and interviews conducted on 11/12/25 at 9:30 a.m. and again at 10:00 a.m. with caregivers/certified medication aides (CMAs)/cooks (D and H) in buildings one and two of the facility regarding the storage and disposal of sharps containers revealed: *Each of their medication carts had a sharps container in the bottom drawer. *They both confirmed that when a sharps container was full, it was to be placed in a biohazard bag (a special red bag used to transport sharp, contaminated items safely) and given to director C for disposal. *Both caregiver/CMA/cook D and H were unsure of where the full sharps containers were disposed of by director C, and whether there was a policy and procedure for the staff to follow. 2. Observation and interview on 11/12/25 at 12:20 p.m. with caregiver/CMA/cook H during medication administration revealed: *Caregiver/CMA/cook H entered the medication storage room without performing hand hygiene,	S 130		

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S 130	Continued From page 2 unlocked the medication cart, and prepared resident 8's medication. *She administered the medication to resident 8, returned to the medication cart, and documented the administration in resident 8's medication administration record (MAR). *She did not perform hand hygiene before or after the medication administration process. *She agreed that she should have performed hand hygiene before and after she completed resident 8's medication administration task. 3. Observation and interview on 11/12/25 at 2:30 p.m. with caregiver/CMA/cook D during medication administration revealed: *Caregiver/CMA/cook D entered the medication storage room without performing hand hygiene, unlocked the medication cart, and prepared resident 1's medication. *She administered the medication to resident 1, returned to the medication cart, and documented the administration in resident 1's MAR. *She did not perform hand hygiene before or after the medication administration process. *She agreed that she should have performed hand hygiene before and after she completed resident 1's medication administration task. 4. Interview on 11/12/25 at 2:55 p.m. and again on 11/13/25 at 2:15 p.m. with director C regarding infection control procedures and practices revealed: *The facility lacked an active infection control program, and no one had been appointed as an infection control preventionist to oversee it. *She stated, "Facility policies are needed for everything," and "I have a copy of the state regulations, but have no policies for many things." *She confirmed that the facility had not regularly monitored or reported infections through quality	S 130		

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S 130	Continued From page 3 assurance and performance improvement (QAPI) or staff meetings. *She was responsible for disposing of the full sharps containers brought to her by staff members. *She stated she would place the bag staff brought her, containing the full sharps containers, into another red biohazard bag (double-bagged) and then put it in the regular trash. *She was unaware that biohazard sharps containers should be disposed of at a permitted municipal solid waste landfill or facility. *She confirmed there was no policy for the disposal of the sharps containers. *Her expectation would have been for staff to wash their hands or use hand sanitizer before, after, and between residents during the medication administration process. 5. Interview on 11/13/25 at 2:40 p.m. and again at 4:30 p.m. with owner/administrator A regarding infection control procedures and practices revealed: *She stated, "Our policies need updating, and new ones still need to be completed," and "We use the policies from the previous owner, but I admit that we do not currently have all the necessary policies in place." *She confirmed that the facility's current policies and procedures have not been reviewed on an annual basis or by the governing body. *She confirmed that the facility lacked an active infection control program, and no one had been appointed as an infection control preventionist to oversee it. *She confirmed that the facility had not regularly monitored or reported infections through QAPI or staff meetings. *She confirmed there was no policy for the disposal of the sharps containers.	S 130		

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S 130	Continued From page 4 *Her expectation would have been for staff to wash their hands or use hand sanitizer before, after, and between residents during the medication administration process. 6. Review of the provider's revised June 2014 Proper Technique for Handwashing policy revealed: *"Policy: All employees will know and follow proper handwashing techniques." *"Procedure: 1) Turn on water 2) Wet your hands 3) Liquid Soap 4) Lather and scrub for at least 20 seconds ("Happy Birthday to me") 5) Leave water running while you dry hands completely with paper towel 6) Use same paper towel to turn off the faucet and then throw away (don't continue to dry hands)." *"Washing Hands: -Initially when coming to work -Before and after each resident contact -Before and after putting on gloves -Before, during and after the preparation of food -After using the toilet -After smoking -After blowing your nose, coughing, sneezing -After any accidental contact with blood or body fluids." 7. Review of the Centers for Disease Control and Prevention website (CDC.gov) (a United States national health authority website) on "Clinical Safety: Hand Hygiene for Healthcare Workers" dated February 27, 2024, revealed the following information: *"1. Wet hands with water." *"2. Apply the manufacturer-recommended	S 130		

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S 130	Continued From page 5 amount of product to your hands." *"3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers." *"4. Rinse hands with water and use disposable towels to dry. Use a clean disposable towel to turn off the faucet." An infection control policy was requested on 11/12/25 from director C, and the only infection control policy provided was the provider's revised January/2023 'Covid-19/Additional Cleaning, Disinfecting Infection Control Procedures' policy. It revealed: *There had been no mention of oversight by a designated staff member for the infection control program or for ensuring infection control procedures and practices were followed to monitor and report infections. 8. On 11/13/25 at 2:00 p.m., a sharps disposal policy was requested from director C. 9. On 11/13/25 at 2:55 p.m., director C stated they did not have a sharps disposal policy. Refer to S400.	S 130	*The facility will designate a healthcare personnel to be responsible for the implementation of the infection prevention and control program. The designee will also be responsible for monitoring and reporting infections, proper disposal of sharps containers and ensuring proper glove use and hand hygiene while administering medication. *Policies and procedures for disposal of sharps containers will be created. *Policies and procedures for handwashing will be updated. *(RN) K will reeducate two of two CMAs D and H on proper hand hygiene while administering medication. *All staff will be educated on the new and updated policies and procedures. *Proper hand hygiene while administering medication will be monitored and tracked weekly in QAPI meetings by (RN) K, Director C and Administrator A for 4 weeks, then once a month for 3 months, then once quarterly until 100% compliance.	12/28/2025
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing	S 200		

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S 200	Continued From page 6 facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview the provider failed to continuously maintain egress free of obstructions that would prevent its use to a public way for one of three observed facility exit doors (western hallway exit). Findings include: 1. Observation on 11/12/2025 at 12:00 p.m. with maintenance supervisor B in the western hallway revealed one hallway exit door at the west end of the building which had an exterior elevated concrete landing with steps that led to an unimproved (dirt/grass surface) area adjacent to the courtyard and did not have any connecting sidewalks to a public way. Interview with maintenance supervisor B on 11/12/2025 at 12:00 p.m. at the time of the observation confirmed those findings.	S 200	*Owner/Maintenance Supervisor B is working with a contractor to create a ramp connecting access to a public way from the western exit.	12/28/2025
S 275	44:70:04:01 Governing Board Each facility operated by a limited liability partnership, a corporation, or a political subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this chapter pertaining to the governing body. This Administrative Rule of South Dakota is not	S 275		

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S 275	Continued From page 7 met as evidenced by: Based on interview and policy review, the governing body failed to ensure the facility was administered in a manner that ensured the daily overall management, resident care, and resident safety was in compliance with the administrative rules of South Dakota, 44:70, Assisted Living Centers regulations for: *Infection prevention. *Background checks. *Disease prevention. *Resident admissions. *Nursing policies and procedures. *Hospice services. *Assessment of residents with cognitive impairments. *Dietetic Services. *Food supply. *Written dietetic policies. *Resident rights. Findings included: 1. Interview on 11/13/25 4:49 p.m. with owner/administrator A regarding her role as the administrator revealed that she had assumed ownership of the facility in July 2022 and was the full-time administrator. She stated she had no prior experience working in an assisted living center (ALC) before assuming ownership of the facility and had relied on the previous ALC advisor for guidance. She was responsible for "fixing things", "helping director C", "putting out small fires", "making relationships", and "making people happy". The governing body was composed of owner/administrator A, owner/maintenance supervisor B, and director C.	S 275		

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S 275	Continued From page 8 The governing body was interviewed for these areas of deficient practice that were identified and referred to above as areas of concern. Review of the provider's June 2025 Quality Assurance policy revealed: "Procedure: The QA team will meet weekly or quarterly for ongoing evaluation of the quality of services provided to the resident's and staff these facilities." "Components of the QA evaluation shall include: -Establishment of facility standards -Review of resident's services to identify deviations from the standards and actions to be taken to correct -Resident satisfaction -Utilization of services provided -Documentation of evaluation" Refer to S130, S285, S315, S320, S352, S400, S432, S443, S450, S465, S474, and S782	S 275	The governing body will hold monthly QA meetings to ensure the facility is administered in a manner that overall management, resident care and resident safety is in compliance with Administrative Rules of South Dakota 44:70, Assisted Living Centers. *Weekly QAPI meetings will be held by Owner/Administrator A, Director C and (RN) K to assist and ensure additional compliance with activities of daily living, resident quality of life, infection prevention and grievances.	12/28/2025
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, the administrator failed to	S 280		

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S 280	Continued From page 9	S 280		

ensure the facility was managed in a manner to ensure:
*A process was established and maintained to verify that the individuals hired did not have a history of abuse or neglect.
*Nursing assessment and documentation had been completed.
*The residents' right to formulate an advance directive upon admission had been discussed with those residents.
*The facility and the hospice provider implemented a care plan that would have delineated the responsibility of each provider.
Findings include:

1. Interview on 11/13/25 at 2:40 p.m. with owner/administrator A regarding her role with new hires revealed:
*She had not established or maintained a process to verify if newly hired individuals had a history of abuse or neglect.
*She was unaware that verification of abuse or neglect for newly hired individuals was a requirement.
*She confirmed that employees C, D, G, H, and I had no background checks or documentation in their personnel files to verify they had no history of abuse or neglect.

Interview on 11/13/25 at 4:49 p.m. with owner/administrator A regarding her role as the administrator revealed that she had assumed ownership of the facility in July 2022 and was the full-time administrator. She stated she had no prior experience working in an assisted living center (ALC) before assuming ownership of the facility and had relied on the previous ALC advisor for guidance. She was responsible for "fixing things", "helping director C", "putting out small fires", "making relationships", and "making

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S 280	Continued From page 10 people happy". She agreed that the facility would benefit from increased registered nurse (RN) hours, but confirmed she was not actively advertising for an RN to provide additional coverage. Administrator A agreed it was not acceptable for a resident to not have a code status on file who had been in the facility for a year and a half. She knew director C had been calling the hospice provider for the hospice binder, but agreed they did not have a developed hospice care plan available in the facility. A copy of the administrator's job description was requested from director C on 11/13/25 at 3:30 p.m., but was informed there was no such job description. Refer to S285, S315, S320, S352, S432, S443, and S782	S 280	*Owner/Administrator A will perform background checks on all current employees and establish a process for all new employees. *Policies and procedures for background checks will be created. *Administrator job description will be created *Policies and procedures for administrator job description will be created. *Policies and procedures for evaluation of needs will be created. *Owner/Administrator A, Director C and (Rn) K will track resident assessments and documentation through weekly QAPI meetings. *Owner/Administrator A and (RN) K will hold and document monthly resident awareness meetings. Changes, reminders and happenings will be discussed on the administration side of things and residents can address any questions or concerns. *Policies and procedures for resident awareness meetings will be created. *All staff and residents will be reeducated on the resident bill of rights. *All staff will be educated on new and updated policies and procedures.	12/28/2025
S 285	44:70:04:03 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Personnel on duty must be awake at all times, except as provided in § 44:70:03:02.01. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or personnel on contract.	S 285		

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S 285	Continued From page 11 This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure that five of five reviewed employees (C, D, G, H, and I) had a history of abusing another person before they were hired. Findings include: 1. Review of the personnel files for employees C, D, G, H, and I revealed that they: *Did not have background checks completed when they were hired. 2. Interview on 11/13/25 at 2:15 p.m. with director C regarding new personnel revealed: * She was unsure why there wasn't a process to verify if newly hired individuals had a history of abuse or neglect. -She stated that owner/administrator A was responsible for ensuring new hires had no history of abuse or neglect of another person before hiring. *She confirmed that she was unable to locate any background checks on employees (C, D, G, H, and I) in their personnel files. 3. Interview on 11/13/25 at 2:40 p.m. with owner/administrator A regarding new personnel revealed: *She had not established or maintained a process to verify if newly hired individuals had a history of abuse or neglect. *She was unaware that verification of abuse or neglect for newly hired individuals was a requirement. *She confirmed that employees C, D, G, H, and I did not have any background checks or other documentation in their personnel files to verify they had no history of abuse or neglect.	S 285		

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S 285	Continued From page 12 4. On 11/13/25 at 2:00 p.m., a background check policy was requested from director C, and she stated that they did not have one. Refer to S400	S 285	*Owner/Administrator A will perform background checks on all current employees and establish a process for all new employees. *Policies and procedures for background checks will be created. *All staff will be educated on new policies and procedures. *Background checks will be monitored and tracked by Owner/Administrator A, Director C and (RN) K weekly in QAPI meetings until 100% compliance	12/28/2025
S 315	44:70:04:07 Prevention And Control Of Influenza 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. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to document a refusal or an administration of an influenza vaccination for one of six sampled residents (1). Findings included: 1. Review of resident 1's care record revealed she had an admission date of 7/1/24. There was no documentation of either the resident's refusal or the administration of an influenza vaccination during the 2024 or 2025 influenza seasons. Interview on 11/13/25 at 10:07 a.m. with director C regarding resident 1 confirmed there was no documentation that the influenza vaccination had been given or refused during the 2024 or 2025 influenza seasons. She stated it was her responsibility to fill out the refusal form when a	S 315		

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(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 315	Continued From page 13 resident refused, and that document was to be recorded in the resident's care record. A copy of the influenza policy was requested from director C on 11/13/25 at 8:55 a.m., but was informed there was no such policy. Refer to S400	S 315	*Policies and procedures for influenza will be created. *All staff will be educated on new policies and procedures. *Influenza vaccinations will be monitored and tracked upon admittance and at time of annual vaccinations weekly through QAPI meetings until 100% compliance.	12/28/2025
S 320	44:70:08 Prevention And Control Of Pneumonia Each facility shall arrange for an immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage a resident to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded in the resident's care record. 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 document a pneumonia vaccination or its refusal for one of six sampled residents (1) within fourteen days of their admission. Findings included: 1. Review of resident 1's care record revealed she had an admission date of 7/1/24. There was no documentation of her pneumonia vaccination or refusal. Interview on 11/13/25 at 10:07 a.m. with director C regarding resident 1 confirmed there was no documentation for the pneumonia vaccination or	S 320		

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S 320	Continued From page 14 refusal. She stated it was her responsibility to fill out the refusal form when a resident refused, and that document was to be recorded in the resident's care record. Review of the provider's 2/9/21 Pneumococcal Vaccination policy revealed: "On Admission, resident's physician will be sent admission form to complete which includes information on pneumococcal vaccination history." "If information is unknown by physician, resident will be addressed as to knowledge and location of any prior vaccination, and if none, will be given consent form to either set up appointment with primary care physician to receive, or decline vaccination option. This documentation will be saved in resident file." "Resident is mandated to see primary care at minimum of 1x year for yearly Medicare evaluation, and vaccinations will be addressed with physician and resident at these appointment as desired by physician/resident to keep resident current for ALF [assisted living facility] paperwork."	S 320	Policies and procedures for pneumococcal vaccination will be created. *All staff will be educated on new policies and procedures. *Pneumococcal vaccinations will be monitored and tracked upon admittance and at the time of annual vaccinations weekly through QAPI meetings until 100% compliance.	12/28/2025
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the	S 352		

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S 352	Continued From page 15 provider failed to ensure an evaluation of needs was completed 30 days after admission, for one of six sampled residents (2), and an annual evaluation of needs was completed for two of six sampled residents (1 and 2). Findings included: 1. Review of resident 1's care record revealed she had an admission date of 7/1/24. Her admission evaluation of needs was completed on 7/2/24, and her 30-day evaluation of needs was completed on 8/12/24. There was no documentation that her annual evaluation of needs had been completed. 2. Review of resident 2's care record revealed she had an admission date of 5/22/24. Her admission evaluation of needs was completed on 5/22/24. There was no documentation that her 30-day evaluation of needs and her annual evaluation of needs had been completed. Interview on 11/13/25 at 11:17 a.m. with director C regarding resident 1 and resident 2 confirmed that there was no documentation that resident 2's 30-day and resident 1 and resident 2's annual evaluation of needs were completed. She stated it was her and registered nurse (RN) K's responsibility to have completed all evaluations of needs for the residents. Interview on 11/13/25 at 4:45 p.m. with owner/administrator Av regarding resident 1 and resident 2's incomplete documentation revealed that she stated it was RN K's responsibility to have completed an evaluation of needs for the residents. A copy of the evaluation of needs policy was	S 352		

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S 352	Continued From page 16 requested from director C on 11/13/25 at 3:30 p.m., but was informed there was no such policy. Refer to S400	S 352	* Policies and procedures for evaluation of needs will be created. *Owner/Administrator A, Director C and (RN) K will track resident assessments and documentation through weekly QAPI meetings until 100% compliance and monthly there after indefinitely for annuals and/or change of needs. *All staff will be educated on new policies and procedures.	12/28/2025
S 400	44:70:05:01 Nursing Policies And Procedures The facility shall establish and maintain policies and procedures that provide nurses and other healthcare personnel with methods of meeting the facility's administrative and technical responsibilities in providing care to residents. The policies must include: (1) The noting of diagnostic and therapeutic orders; (2) The assignment of the nursing care of residents; (3) Administration and control of medications; (4) Assessment and documentation by nurses; (5) Documentation by healthcare personnel; (6) Infection control; (7) Resident safety; (8) Delineation of orders from nonphysician practitioners; and (9) Activities of daily living to maintain each resident's physical functioning and personal care. This Administrative Rule of South Dakota is not met as evidenced by: Based on a review of the provider's operating policies and procedures manual and interviews, the provider failed to establish and maintain policies and procedures for the facility personnel to fulfill responsibilities in providing care to residents. Findings include:	S 400		

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S 400	Continued From page 17 1. Review of the provider's operating policies and procedures manual, along with requests made during the survey on 11/12/25 and 11/13/25, revealed that the facility did not have and could not provide the following policies and procedures. -Food storage policy -Pneumonia vaccine policy -Influenza vaccine policy -Evaluation of resident needs [annual] policy -Hospice policy -Emergency food supply policy -Admission policy -Provision of care policy -Administrator job description policy -Cognitive screen policy -Resident personal mail policy -Sharps disposal policy -Background check policy 2. Interview on 11/12/25 between 10:35 a.m. and 11:30 a.m. with caregiver/CMA/cook E in the kitchen revealed: *There were no dietary policies in the kitchen for staff to utilize. *Caregiver/CMA/cook E stated "the policy book was in director C's office." -She was unsure whether the kitchen department had many policies for staff use. 3. Interview on 11/13/25 at 1:50 p.m. with caregiver/CMA/cook J in the kitchen revealed: *She was unsure where the dietary policies and procedures were kept for staff to utilize. *She confirmed that there were no dietary policies in the kitchen for staff to follow. 4. Interview on 11/12/25 at 2:55 p.m. and again on 11/13/25 at 2:15 p.m. with director C revealed: * She stated, "Facility policies are needed for	S 400	*Policies and procedures will be created for the following: -Food storage policy -Pneumonia vaccine policy -Influenza vaccine policy -Evaluation of resident needs policy -Hospice policy -Emergency food supply policy -Admissions policy -Provisions of care policy -Administrator job description policy -Cognitive screen policy -Resident personal mail policy -Sharps disposal policy -Background check policy *Policies and procedures for dietetic services will be updated. *A copy of all dietary policies and procedures along with all dietary training and continuing education will be kept in the kitchen at all times. *All staff will be educated on new and updated policies and procedures.	12/28/2025

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S 400	Continued From page 18 everything," and, "I have a copy of the state regulations but have no policies for many things." 5. Interview on 11/13/25 at 9:25 a.m. and again at 2:40 p.m. with owner/administrator A revealed: *The facility refers to the state regulations for assisted living centers as guidance. *She stated, "My mind was not on trying to make our own, but to follow the state regulations." *She confirmed that the facility had been using the policies and procedures the prior owner had used. *She confirmed that she had not updated or created new policies and procedures for the facility since taking over ownership in July 2022, and they had not been reviewed and updated each year.	S 400		
S 432	44:70:05:05 Hospice Services A facility that admits or retains a resident who has requested hospice services shall have an order identifying the terminal illness. The facility shall have unlicensed assistive personnel on duty to administer medications to a resident receiving hospice services. At least two personnel must be on duty at all times if the care needs of the resident require additional staffing or if the resident is not capable of self-preservation. Family members may assist with the care of the resident. The facility and hospice agency shall develop a written care plan or service plan that delineates responsibilities. The facility must be equipped with an automatic sprinkler system if a resident becomes incapable of self-preservation. This Administrative Rule of South Dakota is not met as evidenced by:	S 432		

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S 432	Continued From page 19 Based on care record review and interview, the provider failed to implement a care plan between the facility and the hospice provider that delineated the responsibilities of each provider and have it available in the facility for one of six sampled residents (1). Findings included: 1. Review of resident 1's care record revealed hospice admission date of 10/27/25. Review of the folder assembled for resident 1 by the hospice provider revealed it had included hospice admission, consent for care and service agreement, symptom management handout, [hospice provider name] patient and family booklet, non-verbal pain scale handout, hospice team handout, advance directive and medical orders, and "What Is a Hospice Social Worker?" handout. Interview on 11/13/25 at 10:07 a.m. with director C regarding resident 1's hospice binder, and she stated she had called the hospice provider multiple times to bring resident 1's binder. She confirmed there was no coordinated hospice care plan developed and available in the facility. A copy of the hospice policy was requested from director C on 11/12/25 at 5:30 p.m., but was informed there was no such policy. Refer to S400	S 432	*Policies and procedures for hospice will be created. *All staff will be educated on the new policies and procedures. *The facility will review the facility policies and procedures with the hospice provider, as well as, the hospice providers contract signed by both parties to ensure specific responsibilities are followed accordingly. *Facility will include hospice policies and procedures and hospice education in annual training and new hire education.	12/28/2025
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool	S 443		

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S 443	Continued From page 20 for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure an annual cognitive screening was completed for one of six sampled residents (2). Findings included: 1. Review of resident 2's care record revealed she had an admission date of 5/22/24. Her admission cognitive screening was completed on 5/22/24. There was no documentation that an annual cognitive screening was completed. Interview on 11/13/25 at 2:29 p.m. with director C regarding resident 2 confirmed that there was no documentation that her annual cognitive screening was completed. She stated it was her and registered nurse (RN) K's responsibility to have completed the annual cognitive screenings. A copy of the cognitive screening policy was requested from director C on 11/13/25 at 3:30 p.m., but was informed there was no such policy. Refer to S400	S 443	*Policies and procedures for cognitive screening will be created. *All staff will be educated on new policies and procedures. *Cognitive screenings will be monitored and tracked by Administrator A, Director C and (RN) K in weekly QAPI meetings. *The facility has review current resident records and found 100% compliance.	12/28/2025
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in	S 450		

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S 450	Continued From page 21 accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that foods were stored, handled, prepared, and served in a safe and sanitary manner related to: *Inappropriate hand hygiene and glove use in building one of the kitchen for one of one caregiver/CMA/cook (E) while handling and serving food. *Expired packaged food stored in building one of the food storage pantry. Findings include: 1. Observations on 11/12/25 between 11:30 a.m. and 12:30 p.m. with caregiver/CMA/cook E during lunch service revealed: *She washed her hands at the kitchen sink and dried them with a clean paper towel. *She used the same wet, contaminated paper towel to turn off the kitchen faucet, wipe around the sink, and then serve drinks to residents in the dining room. *She was wearing gloves and was plating and serving meals from the kitchen area. *She used those same gloved hands to touch surfaces and utensils, including cupboard doors, bowls, plates, and tongs, and then directly touched ready-to-eat food items (saltine crackers). *With those same gloved hands, she wiped her face/forehead on the back of her right arm and then resumed plating and serving meals without performing hand hygiene and putting on a new pair of gloves. 2. Observation and interview on 11/12/25 at 11:20 a.m. in building one of the food pantry with	S 450		

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S 450	Continued From page 22 maintenance L revealed: *Maintenance L was stocking the pantry with new food products that had been delivered. *Maintenance L stated that he was responsible for stocking the food pantry with the newly delivered food products. *He stated that he stocked the food pantry shelves by moving the existing food forward and then he would place the new food deliveries at the back. -He stated the "back to front rotation" process was to ensure that older stocked food was placed at the front and used before the newer stocked food, which was placed behind when delivered. *Observation of the food products in the pantry revealed the following: *A 26.7-ounce box of Great Value instant potatoes with an expiration date of 11/6/25. *A 15-ounce bag of Victor raisins with an expiration date of 10/18/25. *A 16-ounce jar of Great Value dry-roasted peanuts with an expiration date of 7/7/25. *A 11-ounce box of Great Value vanilla wafer crackers with an expiration date of 4/12/25. *Four 15-ounce boxes of Lion raisins with expiration dates of 10/4/24. *Maintenance L confirmed that the food products listed above had expired, and he was unsure who was responsible for checking the food pantry for outdated items. *Maintenance L immediately removed the items from the pantry. 3. Observation and interview on 11/12/25 at 11:30 a.m. with caregiver/CMA/cook E regarding food storage revealed: *The night shift was responsible for checking the stocked food pantries, refrigerators, and freezers for outdates. *She stated this was done once a month, and she	S 450		

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S 450	Continued From page 23 was unsure if there was a tracking form that staff used to document their monthly checks. *She was unsure if there was a policy for food storage. 4. Interview on 11/12/25 at 4:15 p.m. with director C regarding food storage revealed: *She stated that the kitchen staff in buildings one and two were responsible for checking the stocked food pantries for expiration dates. *She believed the night staff checked the food supply for outdates at least monthly. *She agreed that the facilities' food supply should be regularly checked and tracked for expiration dates. *She confirmed that the facility had no process for staff to track and document monthly food supply checks, and there was no food storage policy available. 5. Review of the provider's June 2014 Proper Techniques for Food Preparation policy revealed: *"Procedure: *"1) Wash hands following appropriate handwashing technique *"..4) Wear gloves when preparing and serving ready-to-eat foods such as fresh fruits and vegetables, sandwiches, and salads *"5) Use appropriate clean utensils to limit contact with foods that do not need to come in contact with hands *"6) Change gloves between tasks *".8) Change gloves after sneezing, wiping nose, touching own face or hair, or with contact with potentially contaminated surface, like refrigerator handle, drawer handle, or cupboard door." 6. Review of the provider's June 2014 Proper Food Serving Practices policy revealed: *"Procedure:	S 450		

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S 450	Continued From page 24 *"1) Wash hands following proper handwashing techniques *"2) Avoid touching ready-to-eat foods such as sandwiches, fresh fruit, vegetables, cookies, and bread." 7. On 11/12/25 at 4:15 p.m., a food storage policy was requested from director C, and she stated they did not have one. Refer to S400	S 450	*Owner/Administrator A will reeducate Caregiver/CMA/Cook E on proper hand hygiene and glove use while handling and serving food. *Policies and procedures for handwashing will be updated. *Policies and procedures for food handling and preparation techniques will be updated. *Policies and procedures for food storage will be updated. *Owner/Administrator A and Director C will monitor and track proper hand hygiene and glove use while handling and serving food and food storage once a week for 4 weeks, then once a month for 3 months, then once quarterly until 100% compliance. *All staff will be educated on new and updated policies and procedures.	12/28/2025
S 465	44:70:06:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, menu review, and policy review, the provider failed to maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned emergency menus for three days. Findings include: 1. Observation on 11/12/25 between 3:30 and 4:00 p.m. in buildings one and two of the two food pantries and menus revealed: *There was no 3-day emergency food supply on-site.	S 465		

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S 465	Continued From page 25 2. Interview on 11/12/25 at 4:00 p.m. with caregiver/CMA/cook H regarding the emergency 3-day food supply revealed: *She was unsure whether there was a 3-day emergency food supply at the facility and was unaware of where it would be stored if it was on-site. 3. Phone interview on 11/13/25 at 10:59 a.m. with registered dietician (RD) F regarding menus revealed: *She visited the facility every month, completed resident nutritional assessments, and addressed any concerns. *She stated that she completed annual training for the kitchen staff and for new hires. *The facility menus were reviewed, updated, and signed every six months. *She was unaware of a 3-day emergency menu for the facility. 4. Interview on 11/13/25 at 2:15 p.m. with director C and at 2:40 p.m. with owner/administrator A regarding the emergency 3-day food supply revealed: *The facility census between buildings one and two was 27. *They were unaware that a 3-day emergency food supply was required to be on-site. *They were unaware that a 3-day emergency menu was required. *They confirmed that there was no 3-day emergency menu or food supply, and that the facility had no policy in place for a 3-day emergency food supply. 5. On 11/12/25 at 4:15 p.m., an emergency food supply policy was requested from director C, and she stated they did not have one.	S 465		

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(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 465	Continued From page 26 Refer to S400	S 465	*Policies and procedures for emergency food supply will be created. *The facility will maintain and onsite supply of perishable and nonperishable foods to meet the requirements of planned menus for 3 days. *The facility shall maintain a additional supply of nonperishable foods as part of the facility's emergency preparedness plan. *The facility will prepare a 3 day emergency menu as well. *All staff will be educated on new policies and procedures. *The facility monitors and tracks the food supply weekly, but will start documenting it through the weekly QAPI meetings.	12/28/2025
S 474	44:70:06:08 Written Dietetic Policies The facility shall have written policies and procedures that govern all dietetic activities. The policies and procedures must include food handling procedures, length of duration for leftovers, and opened packages of commercially prepared food in accordance with chapter 44:02:07. The facility shall review the policies and procedures yearly and revise as necessary. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to establish and maintain dietetic policies for kitchen personnel related to storage, labeling, and discarding of food to ensure safe and sanitary food environments in buildings one and two of the kitchens. Findings include: 1. Observation and interview on 11/13/25 at 1:50 p.m. with caregiver/cook J in building 2 of the kitchen revealed: *Inside the refrigerator, there was the following: -An unlabeled Tupperware container holding a white sauce, with a piece of masking tape on the lid marked 11/7/25. -An unlabeled clear squeeze bottle holding a white liquid, with no open or use-by date. *Caregiver/CMA/cook J stated that the Tupperware container contained "tartar sauce" and the squeeze bottle contained 'ranch dressing."	S 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41075	A. BUILDING: _____ B. WING _____	C 11/13/2025

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S 474	Continued From page 27 *She stated leftover items should have been removed and discarded after three days. *She did not know how long the squeeze bottle of white sauce (ranch dressing) had been in the refrigerator. *She stated that she was trained to discard leftovers after three days. *She stated that the night staff were responsible for checking the refrigerators for outdates. *She confirmed that the leftover food items did not have any use-by dates marked on them. *She was unsure whether the kitchen department had a policy for opened and leftover food. *She removed the containers from the refrigerator to discard. *There were no dietary policies in the kitchen for staff to utilize. 2. Interview on 11/13/25 at 2:00 p.m. with caregiver/CMA/cook G regarding food storage, labeling, and discarding policy revealed: *After reviewing the provider's operating policies and procedures manual, she was unable to supply a policy for food storage, labeling, and discarding. 3. Interview on 11/13/25 at 2:15 p.m. with director C and at 2:40 p.m. with owner/administrator A about a food storage, labeling, and discarding policy revealed that they confirmed there was no policy available for the facility. 4. On 11/12/25 at 4:15 p.m., a food storage policy was requested from director C, and she stated they did not have one.	S 474	*Policies and procedures for food storage will be updated. *A copy of all dietary policies and procedures along with all dietary education and continuing education will be kept in the kitchen at all times. *All staff will be educated on updated policies and procedures. *All new and annual employee dietary education will be monitored and tracked weekly until 100% compliance after a new hire and after annual continuing education.	12/28/2025
S 782	44:70:09:02(7) Facility To Inform Resident Of Rights	S 782		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 782	Continued From page 28 The information must contain: (7) The resident's right to formulate a durable power of attorney for health care as provided in SDCL chapter 59-7 and a living will declaration as provided in SDCL chapter 34-12D; and 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 documented advance directives had been in place for one of six sampled residents (2). Findings included: 1. Review of resident 2's care record revealed she had an admission date of 5/22/24. Her diagnoses included high blood pressure, osteoarthritis, and difficulty with speech. There was no documentation to support her advanced directive, or code status had been reviewed and documented at the time of her admission. Her cognition would have allowed her to make her own decision regarding her care. Interview on 11/13/25 at 10:03 a.m. with caregiver/cook J regarding resident 2, and she stated that resident 2 did not talk anymore. The staff had communicated with her through thumbs up and thumbs down. Interview on 11/13/25 at 10:43 a.m. with caregiver/certified medication aide (CMA) D revealed that if resident 2 had a medical emergency, she would have first called director C, then registered nurse (RN) K, then owner/administrator K, and lastly resident 2's son	S 782		

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S 782	Continued From page 29 to get the family's wishes. Interview on 11/13/25 at 2:35 p.m. with director C regarding resident 2, and she stated that the resident did communicate when she was first admitted, but had been declining. She had talked to the family several times to decide resident 2's code status, but the family had not made a decision. She stated she had reached out to the provider to have them assist with getting a code status for resident 2. Interview on 11/13/25 at 4:45 p.m. with owner/administrator A revealed that she agreed it was not acceptable for a resident to not have a code status on file who had been in the facility for a year and a half. Review of the provider's revised January 2023 Record Services policy revealed the facility will keep the resident records which include "POA/ [power of attorney] LW/[living will] DNR [do not resuscitate]" documents.	S 782	*Policies and procedures for advanced directives will be created. *The facility will complete advance directives at the time of admission. *All staff will be educated on new policies and procedures. *The facility reviewed current resident charts and all charts were in 100% compliance for advance directives. *Resident charts will be monitored and tracked after admissions weekly through QAPI meetings until 100% compliance.	12/28/2025