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
	11055	A. BUILDING: _____ B. WING _____	C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF BROOKINGS LLC	2015 8TH STREET SOUTH BROOKINGS, SD 57006

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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 8/27/24 through 8/30/24. Edgewood Greenleaf Brookings LLC was found not in compliance with the following requirements: S095, S145, S167, S169, S173, S201, S305, S450, S630, S670, S820, and S1050. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted from 8/27/24 through 8/30/24. The areas surveyed included abuse and neglect. Edgewood Greenleaf Brookings LLC was found not in compliance with the following requirement: S838.	S 000		
S 095	44:70:02:05 Housekeeping Cleaning Methods And Equipment The facility shall establish written housekeeping procedures for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two housekeeping carts were secured by two of two housekeepers (F and J).	S 095	Modification to housekeeping carts completed on 09/26/24. All bottles will have bi-lingual labels identifying the chemical. Carts will be kept clean and tidy. Staff have been trained on 09/26/24 on chemical storage policy. Maintenance Tech will conduct a weekly housekeeping audit submitted to Executive Director on a weekly basis until 12/31/24. Executive Director re-educated Housekeepers F & J by having a meeting to discuss in depth written housekeeping procedures, chemical descriptions & proper storage. These documents were translated on paper, bilingually.	09/26/24

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

TITLE: Executive Director

(X6) DATE: 10/31/2024

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S 095	Continued From page 1 Findings include: 1. Observation and interview on 8/27/24 at the following times in the assisted living wing revealed at: *10:55 a.m. outside of resident room 21 was an unattended housekeeping cart. On top of the housekeeping cart were several containers of chemicals including peroxide and restroom disinfectant. *11:00 a.m. housekeeper F exited another resident's room. Interview at that time revealed she was unable to understand what the surveyor was asking. When asked if she spoke English she replied "learning." 2. Observation and interview on 8/27/24 at the following times in the memory care unit revealed at: *11:15 a.m. housekeeper J was standing beside a housekeeping cart. There were several chemicals on top of the cart. Interview at that time with housekeeper J revealed she did not understand English and was unable to communicate with the surveyor. *11:20 a.m. the above housekeeping cart was unattended with chemicals on top of it. There were residents in the memory care unit who were ambulating past the unattended unsecured housekeeping cart. 3. Observation on 8/28/24 at 8:15 a.m. in the memory care unit hallway revealed an unattended unsecured housekeeping cart with chemicals on top of it. There were two large spray bottles attached to the side of the cart with liquid contents. The spray bottles did not have labels on them identifying the contents. One of the spray bottles had a large strand of black hair attached to it.	S 095	All staff were provided the chemical storage policy by Executive Director at staff meeting. No changes made to this policy with the exception of bilingual language. Executive Director provided education in regards to proper labeling and chemical storage on the housekeeping carts. Weekly Housekeeping audits will occur during the day time on random days of the week. Results will be reviewed with QAPI 1 time per month through 12/31/24. QAPI will determine if weekly audits shall continue or if monthly audits will be sufficient.	

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S 095	Continued From page 2 4. Observation on 8/29/24 at 7:45 a.m. in the assisted living wing across from the kitchen revealed an open door with a set of keys hanging from the unlocked door. Inside of the unattended room were chemicals and cleaning supplies. Residents walked by the open door. 5. Interview on 8/29/24 at 9:00 a.m. with executive director A, clinical services director B, and maintenance technician D regarding the above observations and interviews revealed: *The housekeeping carts should have been secured when unattended. *The door to the housekeeping storage room should have been closed and locked. *Housekeepers F and J spoke minimal English. *The facility had used an app on their phones to communicate with both housekeepers. On 8/29/24 at 1:00 p.m. the surveyor requested from executive director A the provider's Storage of Chemicals policy. The policy had not been provided.	S 095		
S 145	44:70:02:12 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install exhaust ventilation for one of three storage rooms (assisted living utility room).	S 145	Investigating options for exhaust ventilation with Edgewood Corporate Environmental Director, Keith Jensen. Active Heating will add a powered exhaust ventilated fan by 10/31/24.	10/13/24

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S 145	Continued From page 3 Findings include: 1. Observation on 8/30/24 at 9:00 a.m. revealed the utility room in the assisted living unit across the corridor from the kitchen was less than fifty square feet in area, held chemical storage, and had a janitor's floor sink. The utility room was not equipped with exhaust ventilation. The room had no ventilation whatsoever. Interview with maintenance technician D at the time of the observations confirmed those conditions.	S 145		
S 167	44:70:02:17(3) Occupant Protection The facility shall: (3) Provide an emergency staff call system for resident use to summon assistance from staff. The system must be capable of being easily activated by a resident and must register both visually and audibly at the staff station. The system must be utilized and maintained in a manner to ensure it is a consistent and effective means for a resident to alert staff of the need for assistance. The call system must also: (a) Utilize fixed call stations convenient for resident use and activated by a pull cord or other department-approved device. The fixed call stations must be located at each bed, toilet, and bathing facility used by a resident; (b) Be a wireless system with a device carried by a resident; or (c) Have been submitted for review and approved by the department; A call station or device is not required in the resident room of a cognitively impaired resident if a nursing assessment determines the resident would not benefit from the availability;	S 167	Pull cords have been purchased and will be installed by 10/04/24.	10/04/24

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S 167	Continued From page 4 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain nurse calls for two of two resident bathing rooms in the memory care unit (spa shower room and spa tub room). Findings include: 1. Observation on 8/30/24 at 8:15 a.m. revealed the spa shower room in the memory care unit had a nurse call mounted on the wall adjacent to the water closet. The nurse call did not have a cord. 2. Observation on 8/30/24 at 8:25 a.m. revealed the spa tub room in the memory care unit had a nurse call mounted on the wall adjacent to the water closet. The nurse call cord was wrapped around the side grab bar. 3. Interview with maintenance technician D at the time of the above observations confirmed those conditions.	S 167	Type text here	
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;	S 169		

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S 169	Continued From page 5 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to install or maintain door alarming for two of four exterior doors (assisted living lounge and main entrance). Findings include: 1. Observation on 8/30/24 at 8:50 a.m. revealed the exterior door from the lounge in the assisted living was equipped with a door alarm. Testing the alarm by opening the door revealed the alarm did not sound. Interview with maintenance technician D at the time of the observation and testing confirmed that condition. He stated the door alarm had been disabled. Further interview revealed the main entrance door was not equipped with a door alarm. Interview with executive director A at 10:00 a.m. revealed the assisted living had residents with some cognitive impairment who were not housed in the memory care unit. Neither the lounge exterior door nor the main entrance could be considered monitored door locations.	S 169	The front door is monitored & alarmed by personnel between the hours of 8am-5pm Monday- Friday. The front door is alarmed when personnel is not present. The door is locked from 10pm-5:30am. The door has an egress lock feature with a 15 second emergency crash bar to exit. A SLUMS report is submitted monthly to the RVP and RND to monitor appropriateness of AL residents to reside in AL. This has been ongoing in 2024 and will continue into 2025.	10/14/2024
S 173	44:70:02:17(8-9) Occupant Protection The facility shall: (8) Ensure that any clothes dryer must have a galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in accordance with UL 2158A; and (9) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. A resident may store in the resident's room a maximum of three E-cylinders or seventy-two cubic feet, or	S 173	We have purchased galvenized metal transition ducts and they will be installed by 10/11/24.	10/08/24

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S 173	Continued From page 6 2.040 cubic meters of oxygen on an as-needed basis, in addition to oxygen in use by the resident. If a facility admits or retains a resident not capable of self-preservation, the facility must meet NFPA 101 Life Safety Code, 2012 edition, health care occupancy standards in chapter 18 or 19, or equip the facility with complete automatic sprinkler protection. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install galvanized metal exhaust ductwork for two of two residential dryer locations (memory care laundry and assisted living laundry). Findings include: 1. Observation on 8/30/24 at 8:40 a.m. revealed the memory care laundry room had two Samsung residential style dryers. The dryers had foil paper exhaust ducting installed. Interview with maintenance technician D at the time of the above observations confirmed those conditions. He further stated the two dryers in the assisted living also had foil paper ducting installed.	S 173		
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	S 201	Previous inspections & flo rates have been printed & filed. Reports confirmed inspection & flo rates wre completed on: 1.08.2019 1.14.2020 1.07.2021 1.08.2022 1.14.2023 1.15.2024	

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S 201	Continued From page 7 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 met as evidenced by: A. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow tests were not completed dating back to 2018 and a 5-year internal obstruction inspection had not been performed dating back to 2018). Findings include: 1. Record review on 8/30/24 at 8:00 a.m. revealed the required quarterly sprinkler flow tests had not been performed dating back to 2018. 2. Record review on 8/30/24 at 8:10 a.m. revealed the required 5-year internal sprinkler obstruction inspection had not been performed dating back to 2018. Interview with maintenance technician D at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increased the risk of death or injury due to fire. B. Based on observation and interview, the provider failed to maintain proper separation of two of four hazardous areas (memory care storage rooms). Findings include: 1. Observation on 8/30/24 at 8:33 a.m. revealed	S 201	Quarterly Flow Testing has been set up with CNR in Sioux Falls to begin in October 2024. 5 year inspection has been set up for 10/13/24 with CNR in Sioux Falls. CNR will ensure we stay on schedule with this requirement. Maintenance Specialist, Thad Bereth has added this task to our TELS Maintenance Communication System.	10/13/2024

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S 201	Continued From page 8 the unlabeled storage room was over 100 square feet in area and contained copious amounts of combustible items (toilet paper, plastic liners for trash, paper envelopes) and cleaning chemicals. The door to the storage room was not equipped with a self-closing device. 2. Observation on 8/30/24 at 8:33 a.m. revealed the mechanical room adjacent to room 116 was over 100 square feet in area and contained copious amounts of combustible items (kleenex, paper towels, and cardboard boxes) and cleaning chemicals. The door to the mechanical room was not equipped with a self-closing device. Interview with maintenance technician D at the time of the observations confirmed those findings. Doors to hazardous areas were required to be self-closing.	S 201	Self-closing devices have been installed in room 116 & the unmarked maintenance room on 08/30/24.	08/30/24
			Current employess TB & health history forms are up to date as of 09/26/24. TB's and health history forms will be completed per policy on new hires. Audits will be completed monthly by office assistant until 12/31/24.	09/26/24
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel file review, interview, and policy review, the provider failed to ensure four of eight sampled employee files (A, F, G, and I) had been evaluated by a licensed health professional to be free of communicable diseases within fourteen days of being hired.	S 305		

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S 305	Continued From page 9 Findings include: 1. Review of the following employee files revealed: *Employee A had a hire date of 10/27/17. *Employee F had a hire date of 1/23/24. *Employee G had a hire date of 4/1/22. *Employee I had a hire date of 8/20/20. *There was no documentation in the above employee personnel files they had been evaluated by a licensed health professional to be free of communicable diseases within fourteen days of being hired. 2. Interview on 8/28/24 at 11:30 a.m. with executive director A regarding employees A, F, G, and I revealed they did not have documentation in their individual employee files they had been evaluated by a licensed health professional to be free of communicable diseases within fourteen days of being hired. On 8/29/24 at 1:00 p.m. the surveyor requested from executive director A the provider's Free of Communicable Disease policy. The policy had not been provided.	S 305	Employees A, F, G & I's Health Forms were not completed. With new hires, CSD will ensure Health Forms & TB's are completed within 14 days of hire. Monthly audits will be completed by CSD or LPN through 12/31/24. QAPI will determine if monthly audits will be sufficient.	
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 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	S 450	Dining Director met with Dining Team & re-educate on policies & procedures on 09/03/24. Dining Director will meet with Executive Director weekly until 12/31/24 to discuss the weekly sanitation checklist. Dining Director met with Cooks H & K on proper hand hygiene on 08/30/24. Dining Director educated staff on temperature monitoring of the dishwasher on 09/03/24.	09/03/24

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S 450	Continued From page 10 review, the provider failed to maintain a safe and sanitary food service environment in one of two kitchens (assisted living wing) related to: *Hand hygiene by two of two cooks (H and K) during meal service preparation. *Appropriate monitoring of one of one low-temperature dishwasher. *Ongoing monitoring of temperatures for the kitchen refrigerator, pantry refrigerator, chest freezer, white pantry freezer, and the dining room refrigerator. Findings include: 1. Observation on 8/27/24 at 11:25 a.m. in the kitchen revealed: *Cook H had a blue glove on her left hand. She: -Removed the tray of individual bacon wrapped meatballs from the oven. -Took the food thermometer and checked the temperature of the meatballs. -Transferred the meatballs from the oven tray to a pan in the steam table. -Took the soiled tray the meatballs had been on, rinsed the meatball residue from the pan, and placed the pan into the dishwasher. -Took a wet cloth and wiped the kitchen counter. -Removed the blue glove from her left hand. -Removed the clean tray from the dishwasher and placed it into the steam table. -Had not washed her hands and then put on a pair of new gloves. Observation on 8/27/24 at 11:33 a.m. with cook K revealed she had gloves on both hands. She: *Took a large serving spoon, removed pudding from a large container, and placed the pudding into individual serving bowls. *During the above observation cook K had touched the sides of the bowls and opened and closed cupboard doors with those same gloved	S 450	Dining Services Director and our Relias training program will continue to educate staff. Weekly audits will be completed by Dining Services Director. Results will be reviewed at the monthly QAPI meetings.	

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S 450	Continued From page 11 hands. Observation on 8/27/24 at 11:38 a.m. with cook K revealed she continued to wear the same gloves while she dished up the pudding and whipped topping. Observation on 8/27/24 at 11:40 a.m. with cook H revealed she removed her gloves, took a wet cloth, and wiped a spill off of the floor. She had not performed hand hygiene after that. Observation on 8/27/24 at 11:42 a.m. with cooks H and K revealed: *Cook K had just "flipped" a turkey provolone melt sandwich in a frying pan. *Cook H with gloved hands took a hold of the pan and with the spatula removed the sandwich from the pan. She then: -Touched multiple surface areas before taking a knife to cut the sandwich while holding onto the sandwich with those same gloved hands. -Began to plate the food with serving utensils and picked up the buttered bread with those same gloved hands and placed the bread onto the resident's plates. Interview on 8/29/24 at 8:00 a.m. with dining services director L agreed there had been a breach in hand hygiene during the preparation and serving of the noon meal. Review of the provider's July 2024 Dining Services policy and procedure manual revealed: *"Everyone handling food must wash their hands before beginning work and after using the restroom, smoking, eating, handling raw meat, or touching unclean surfaces, including bussing of dishes." *"Single use gloves are designed for one task,	S 450		

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S 450	Continued From page 12 after which they must be discarded. single use gloves should never be used in place of handwashing. Guidelines when using gloves: -Wash hands thoroughly before and after wearing or changing gloves to remove any bacterial buildup. -Once the gloves come in contact with a contaminated surface or you change the type of food being handled, they must be discarded and replaced with clean gloves. -Tongs, spatulas, and other tools should be used wherever possible to pick up food, places garnishes on plates, etc." 2. Observation on 8/27/24 at 11:20 a.m. revealed the temperature logs for the refrigerators, freezers, dishwasher and sanitizing logs were located on the side and on the front of the refrigerator. There were several open blank slots indicating the temperatures had not been documented. Review of the 8/1/24 through 8/26/24 temperature logs revealed: *There were no temperatures documented for the refrigerators and freezers for: -13 out of 26 days on the day shift. -8 out of 26 days on the evening shift. *There were no dishwasher cleaning and sanitizing logs documented 12 out of 26 days on the day shift and the evening shift. Interview on 8/27/24 at 11:25 a.m. with cook H revealed the dishwasher was a low-temperature dishwasher. Interview on 8/29/24 at 8:00 a.m. with dining services director L regarding the documentation of the refrigerators, freezers, dishwasher and sanitizing logs revealed:	S 450		

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S 450	Continued From page 13 *The kitchen staff were responsible to document the above. *Her expectations would have been for the temperatures to have been documented.	S 450		
S 630	44:70:07:04 Storage And Labeling Of Medications All medications must be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight degrees centigrade. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of one medication cart, one of one closet room, and one of one medication storage room (memory care unit) were secured. Findings include: 1. Observation on 8/27/24 at 11:05 a.m. in the assisted living wing revealed a door leading into a room. Inside the room was a small desk and cupboards. One of the cupboards did not have a lock. Inside the unlocked cupboard were over-the-counter medications including Tylenol extra strength, Ibuprofen, Aspirin, and Tums. There were no labels on the bottles identifying who they were for.	S 630	All over the counter medications will have Physician orders and labeled correctly per state regulations. Meds not in compliance were labeled on 9/26/2024. Clinical Services will audit the med cart monthly for medications not labeled for 3 months and then quarterly after. All certified medication aids will be educated to inform licensed nurse of any medications that do not have a label by 09/30/2024. The room without a lock containing the OTC medications has a lock installed by our Maintenance Tech. Maintenance Tech changed the lock to the med room. CSD & LPN Manager are the only ones with the keys to the med room. Results from the med cart audits will be sent to QAPI to determine if the quarterly audits should continue.	09/30/24

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S 630	Continued From page 14 2. Observation on 8/27/24 at 1:30 p.m. in the memory care unit revealed an unlocked unattended medication cart. The computer screen on top of the medication cart was opened and exposed to a resident's medication administration record. At that time executive director A and clinical services director B walked by the unlocked unattended medication cart. Interview at that time revealed they both agreed the cart should have been locked when not in attendance and the computer screen should have been closed. 3. Interview on 8/29/24 at 10:10 a.m. in the memory care unit medication room with clinical services director B regarding the security of the medications and medication room revealed: *The unlocked closet in the assisted living wing was not a medication room. The medications in the room were for the employees. The medications should have been locked in one of the cupboards and not left in the unlocked cupboard. *Residents could have accessed that room and those medications. *All employees had access to the memory care unit medication room. There was one master key everyone had access to and could be used to unlock the medication door. *She agreed the medications had not been secured and should have been. 4. Review of the provider's July 2024 Medication Storage policy revealed: *"To support the medication delivery system he Community must follow these guidelines for the medication storage room/space: -E. "Keep medication room/space locked when not in use."	S 630	The lock has been changed on the med room. Accessible to those with authority to enter per the storage and labeling of medications rule with the SD DOH.The lock was changed on 09/03/24.	

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S 630	Continued From page 15 -F. "Limit access to the medication storage room/space and only allow access by the person(s) assigned on each shift to administer or assist administration, and the appropriate supervisor." Review of the provider's July 2024 Medication Administration policy revealed: *"All medications will be handled, stored, and administered based on the state and Community requirements. -PRACTICE: -B. When medication management is provided by the Community: --3. Only authorized personal of the Community and licensed or registered by the state regulations to administer or provide medications will have access to the locked storage areas."	S 630		
S 670	44:70:07:07 Medication Administration A registered nurse shall provide medication administration training pursuant to § 20:48:04.01 to any unlicensed assistive personnel employed by the facility who will be administering medications. Unlicensed assistive personnel shall receive initial and ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel file review, interview, and policy review, the provider failed to ensure three of three sampled certified medication assistants (CMA) employees (A, G,	S 670	All current medication aides will complete a competency evaluation by 10/18/24 by the CSD. Moving forward, the CMA competencies will be completed with the employee annual review. Competencies were completed with CMA's A, G & I on 10/02/24. CSD will complete these. CSD & LPN will complete these audits at employees' annual review. Results will be shared with QAPI.	10/13/2024

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S 670	Continued From page 16 and I) had received annual competency evaluations. Findings include: 1. Review of employee A's personnel file revealed a hire date of 10/27/17. She had received her CMA certification in 2022. There was no documentation she had received annual CMA competency evaluations. 2. Review of employee G's personnel file revealed a hire date of 4/1/22. There was no documentation she had received annual CMA competency evaluations. 3. Review of employee I's personnel file revealed a hire date of 8/20/20. There was documentation she had received an annual CMA competency evaluation on 12/14/20. There was no further documentation she had received annual CMA competency evaluations in her personnel file. 4. Interview on 8/28/24 at 11:30 a.m. with executive director A regarding the above CMA personnel files revealed: *CMA A had received her certification in 2022. She had rarely worked as a CMA but had passed resident medications awhile ago. *CMAs A, G, and I should have had annual CMA competency evaluations. 5. Review of the provider's July 2024 Medication Administration policy revealed: *K. "In states where Medication Aids administer medications, the standard of practice for medication administration or provision will be established by stare or Community standardized medication administration training." *M. ""A Registered Nurse will determine competency of staff authorized to administer medications where applicable."	S 670	Type text here	

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S 820	44:70:09:08 Privacy And Confidentiality A facility shall provide for privacy and confidentiality for the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to provide privacy and confidentiality for: *One of one closed sample resident (9) who had a fall. *One of seven sampled resident (11) medication administration by one of three observed certified medication assistants (CMA) (I). *One of one computer screen opened and exposed one of one unidentified resident's medical information. *One of one sampled resident's (10) medical information was left unattended in a public area by one of one observed physical therapist (M). Findings include: 1. Observation and interview on 8/28/24 at 8:25 a.m. in the memory care unit with CMA I regarding resident 9 revealed he had: *Been a resident at the facility. *Resided in the memory care unit. *A pressure ulcer on his left hip. *A fall and had been sent to the hospital. *CMA I had taken a photo of him with her personal cell phone and had sent it to a staff member to inform them of his fall. CMA I: -Looked through her personal cell phone photos and found the picture of him lying on the floor with his left hip exposed with the pressure ulcer dressing on his left hip. -Showed the picture of him to the surveyor. -Stated she took photos with her personal cell phone to send to the nurse if they weren't in the	S 820	Cell phones are not to be used to record or share confidential company information or use the company's network to download illegal or inappropriate materials from the internet. Employees have been notified of the cell phone & HIPAA policy on 09/24/24. CSD provided the Privacy & Confidentiality Education. CSD & LPN will continue to monitor this monthly until 12/31/24 & quarterly thereafter. They will report to QAPI. Annual CMA Competencies will occur completed on employee anniversary and staff will be re-educated on the 6 rights of medication administration on 09/26/24. CMA 1 is no longer employed at this facility.	09/26/24

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S 820	Continued From page 18 building. -Usually deleted the pictures but had not deleted that one. Interview on 8/28/24 at 3:00 p.m. with executive director A and clinical services director B regarding resident 9 revealed: *He had been transferred to the hospital on 7/31/24. *Both: -Were unaware CMA I had taken a photo of him. -Agreed it was a breach of privacy and confidentiality. -Agreed staff should not be taking photos with their personal cell phones of residents and keeping the photos on their cell phones. *Clinical services director B stated she had not received the photo of him from CMA I. 2. Observation and interview on 8/28/24 at 8:20 a.m. in the memory care unit dining room with CMA I revealed: *She removed a bottle of Dorzol Timol eye drops from the medication cart. She: -Walked over to resident 11 who was seated at the dining room table. -Administered the eye drops to her. -Walked back to the medication cart and returned the eye drops to the medication cart. -Had not asked resident 11 for permission to administer the eye drops in a public area. *There were other residents in the memory care dining room. Interview at that time with CMA I revealed she usually administered eye drops in each resident's room but resident 11 was already at the dining room table. Interview on 8/29/24 at 10:10 a.m. in the memory	S 820		

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S 820	Continued From page 19 care unit medication room with clinical services director B regarding the above observation of CMA I revealed she should not have administered the eye drops to resident 11 in a public area. Review of the provider's revised November 2018 Applying Medication to the Eye Checklist revealed: *Procedure: -11. "Provided for privacy." Review of the provider's July 2024 Medication Administration policy revealed medications would be administered by trained staff using the six rights of medication administration. 3. Observation on 8/27/24 at 1:30 p.m. in the memory care unit revealed an unlocked unattended medication cart. The computer screen on top of the medication cart was open and exposed to a resident's medication administration record. At that time executive director A and clinical services director B walked by the unsecured unattended medication cart. Interview at that time revealed they both agreed the cart should have been secured when not in attendance and the computer screen should have been closed. 4. Observation on 8/29/24 at 8:30 a.m. in the assisted living wing by the pool table revealed: *Three documents of resident 10's medical information laying on a table not covered. *There were other residents who were in the vicinity of the table. *Physical therapist M: -Had been assisting a resident with ambulation in the hallway. -Made eye contact with the surveyor. -Walked over to resident 10's unattended medical	S 820	ED spoke with Caringedge Therapy Director regarding HIPAA and re-education of her staff on the HIPAA guidelines on 08/30/24. Therapy Director stated she would speak with her staff by 08/30/24.	08/30/24 08/30/24

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S 820	Continued From page 20 information and placed it in a secured area. Interview on 8/29/24 at 9:30 a.m. with executive director A revealed a resident's medical information should not be left unattended. Review of the provider's December 2018 Resident Bill of Rights revealed: *Confidential/HIPPA: -"The resident has the right to privacy, confidential care, and protection of health information." -Healthcare professionals have a duty to protect each resident's healthcare information and privacy." Review of the provider's undated Health Insurance Portability and Accountability Act (HIPPA) learners guide revealed: *"Privacy is about who should and should not have access to health information. Clients [residents] have the right to privacy meaning that information about them should only be available to people who need it to provide care." *"Confidentiality is about preventing someone from hearing or seeing a person's private health records and information unless they have the proper authorization. All health information is confidential. Anyone who possess personal health information is responsible for protecting it." *"Security is the means used to provide privacy and confidentiality. The purpose of security is to ensure that only those persons having authorization may access personal health information."	S 820	State report was submitted	
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment	S 838		

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S 838	Continued From page 21 that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to: *Follow their Abuse Prevention, Intervention, Reporting and Investigation policy. *Report three of three sampled residents (1, 2 and 9) who were at risk for potential abuse and neglect to the South Dakota Department of Health (SD DOH). Findings include: 1. Review of the anonymous online report submitted to the SD DOH regarding resident 1 revealed: *He had attacked an employee. *He had been known to touch other female resident's breasts. *The incidents had been reported to executive director A and clinical services director B who stated they would file a report with the state. *Staff should have additional education provided by the facility regarding resident-to-staff violence. *They had found resident 1 in bed with more than one female resident. Review of resident 1's care record revealed: *His: -Date of birth was 10/26/37.	S 838	CSD completed the state report and submitted to SD DOH. Our Legacy Dementia Training is scheduled for 10.08.24. We will assign all staff to go through the training to be e ducated on how to approcach residents with Dementia,aggressive behaviors & resistance to cares. Care Plans will be reviewed and updated by 10/15/24 to indicate individualized possible approaches to avoid difficult situations in residents with behaviors. Resident 1 has been discharged from facility. CSD will be designated to report incidents to DOH. Education was provided to both CSD & Executive Director by Surveyor. Reports for residents 1,2 & 9 were completed by 08/30/24. CSD will be responsible for updating the service plans by 10/14/24. CSD & LPN will complete the audits monthly until 12/31/24 and then quarterly thereafter. Results will be shared with QAPI.	10/08/24

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S 838	Continued From page 22 -Admission date was 3/19/24. -Diagnoses included mild dementia, agitation, tumor of lung, and bladder disorder. *He: -Had been receiving psychoactive medications for his mood and behaviors. -Had been admitted to hospice on 7/15/24. -Was cognitively impaired. -Resided in the memory care unit. -Had disruptive moods and behaviors. *There was no documentation he had touched other female resident's breasts. Review of resident 2's care record revealed: *Her date of birth was 2/5/45. *Her admission date was on 10/11/21. *She had a diagnosis of Alzheimer's dementia. *She: -Was cognitively impaired. -Resided in the memory care unit. Interview on 8/27/24 at 10:20 a.m. with executive director A regarding resident 1 revealed: *He had tried to choke a caregiver. *He had tried to choke a resident "last week." *They had contacted the family regarding his behaviors. *He got agitated easily and was on 1/2-hour checks. *The family had taken him to [name of hospital] but the hospital declined to admit him. *The [name of another hospital] would not accept him. *The family stayed at the facility during the night and eight hours during the day to assist him. *She had clinical services director B complete the online report to be submitted to the SD DOH regarding resident 1 choking resident 2. Observation and interview on 8/27/24 at the	S 838		

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S 838	Continued From page 23 following times regarding residents 1 and 2 in the memory care unit revealed at: *11:10 a.m.: A personal care attendant assisted resident 1 to the bathroom. He was cooperative during the toileting. *11:45 a.m.: -Resident 1 was seated in a chair in the day room. -Resident 2 was walking up and down the hallway humming to herself. Interview at that time with certified medication assistant (CMA) I revealed: -"Resident 2 was "a roamer" and she walked a lot and hummed to herself." *Observation at 1:45 p.m. revealed.: -Resident 1 was seated in a chair in the day room. -Interview with an unidentified caregiver regarding resident 1 revealed there was no family present during the day, but the family stayed over most nights to assist him. Interview on 8/27/24 at 4:00 p.m. with executive director A, clinical services director B, and licensed practical nurse (LPN) C manager regarding the altercation between resident 1 and 2 revealed: *The incident occurred on 8/19/24 at 7:30 p.m. *Resident 1 had choked resident 2. *A CMA had been at the medication cart on the memory care unit. -She heard noises and witnessed resident 1 removing his hands from around resident 2's neck, --There were red marks on resident 2's neck. *They had notified the family and hospice. -Hospice was supposed to notify the hospice medical director. *That same night they had called the local ED (emergency department) who recommended they	S 838		

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S 838	Continued From page 24 contact [name of hospital ED]. *Resident 1's daughter: -Had called one hospital and they did not want to see him. -Took him to [name of hospital] ED and the hospital did not want to admit him. --Resident 1 was seen at 1:30 a.m. in the [name of hospital] ED. -They arrived back at the facility in the early morning because the family had said "He had not gotten assessed so she brought him back." *Resident 1 had tried to choke a staff member. The CMA had texted clinical services director B but had not said much in that text message. *They had implemented interventions for resident 1. The interventions included: -Staff were to check on him every half hour. -All of the resident's doors were to be locked from the outside after 8:00 p.m. --They confirmed the residents were able to open their room doors from the inside. *Hospice reported tests had confirmed he had a tumor on his lungs so no further medical treatment would be done. *His wife started staying overnight at the facility on 8/30/24. *Resident 1 had an increase in behaviors including: -Pulling the fire alarm. -Urinating on the wall. -Having incontinent bowel movements in the sink. *He had several medication changes. *Hospice had been assisting with seeking an alternate placement for him. *He had been seen by a behavioral management team from [name of hospital] in June 2024. *They were not aware of any incidents where he had touched any female resident's breasts. *He had touched two CMAs inappropriately. *They:	S 838		

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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 838	Continued From page 25 -Had not completed a report for the SD DOH regarding the altercation between residents 1 and 2. -Would try to get the report completed today (8/27/24). -Had educated the staff on interventions for his behaviors. *The leadership team had been in the building when the altercation had occurred. *They had not: -Completed an online report for the SD DOH regarding resident 2. -Notified resident 2's family or physician regarding the 8/19/24 altercation with resident 1. Interview on 8/28/24 at 3:00 p.m. with executive director A and clinical services director B regarding resident 1 and 2 revealed: *Executive director A had contacted resident 1's family regarding him having choked resident 2. *They: -Had not contacted resident 2's family regarding the above incident. -Had not contacted resident 2's physician regarding the above incident. -Were unsure if an incident report had been filled out regarding the red marks around resident 2's neck. -Had not submitted an online report to the SD DOH regarding the resident-to-resident altercation. -Had not completed a thorough investigation of the resident-to-resident altercation between resident's 1 and 2. 2. Observation and interview on 8/28/24 at 8:25 a.m. in the memory care unit with CMA I regarding resident 9 revealed he had: *Been a resident at the facility. *Resided in the memory care unit.	S 838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11055	A. BUILDING: _____ B. WING _____	C 08/30/2024

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S 838	Continued From page 26 *A pressure ulcer to his left hip. *A fall and had been sent to the hospital. *CMA I had taken a photo of him with her personal cell phone and had sent it to a staff member to inform them of his fall. *CMA I looked through her personal cell phone photos and found the picture of him lying on the floor. -That photo revealed his left hip exposed with the pressure ulcer dressing intact to his left hip region. -She showed the picture of him to the surveyor. Review of resident 9's care record revealed: *His date of birth was 7/26/39. *He had been admitted on 7/14/21. *His diagnoses included Alzheimer's Disease, vascular dementia, Parkinson's disease, and degenerative joint disease. *He was admitted to hospice on 7/15/24. *Progress notes indicated on: -7/28/24: "Entered room to give medications and found resident lower body hanging off edge of bed." -7/29/24: "Increased susceptibility to falls. Resident is on hospice care. Has hospital bed. Interventions: make sure bed is in lowest position. Safety check every hour." --His wife and physician had been notified. -On 7/31/24 at 8:30 a.m.: "Writer responded to resident room where he was laying on the floor next to his bed on his right side. He was refusing any movement/vitals (except pulse and oxygen) from staff and facility director [name] was at his side, it was requested to contact hospice for further direction. Hospice was contacted RE: fall and [name] directed nurse to transport to hospital if suspected injury. His wife was contacted as well with wishes for him to be sent to ER. Resident was sent vi ambulance to [name of hospital] ED	S 838		

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S 838	Continued From page 27 (emergency department)." -On 7/31/24 at 4:14 p.m.: "Was admitted to the hospital and received the care he needs. He will continue on Hospice and will be relocating to a nursing home. Discharge date of 7/31/24." Interview on 8/28/24 at 3:00 p.m. with executive director A and clinical services director B regarding resident 9 revealed: *He had a fall on 7/31/24 and had been sent to the hospital. *They had received notification he had passed away on 8/27/24. *The hospice staff contacted the hospice physician with any changes. *They had not submitted an online report to the SD DOH regarding his fall on 8/27/24. Review of the provider's July 2024 Abuse Prevention, Intervention, Reporting and Investigation policy revealed: *B. Intervention: -"1. Upon receiving reports of physical or sexual abuse, the Community Executive Director (or designee) or appropriate personnel, is immediately notified to arrange for the examination of the resident." -"2. The physical examination is conducted by an appropriately licensed professional. --a. The time, date and person completing the examination is recorded in the resident record. --b. The injury is involved (or suspected), law enforcement is to be notified." *C. Reporting: -2. "The Executive Director (or designee notifies the following of a suspected abuse incident: --b. Adult Protective Services. --c. Resident's attending physician. --d. State licensing/certification agency. --e. Resident's legal representative on record."	S 838		

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S 838	Continued From page 28 *D. Investigation: -"2. When an incident or suspected incident occurs, the Executive Director or designee investigates the allegation." -"3. The individual conducting the investigation, at a minimum: --a. Reviews the completed resident report. --b. Reviews the resident's record to determine events leading up to the incident. --c. Interviews the persons reporting the incident. --d. Interviews any witnesses to the incident. --f. Contacts the resident's attending physician and provides an update." -"7. The ombudsman is notified that an investigation is being conducted."	S 838		
S1050	44:70:10:33 Lighting Illumination of at least 30 footcandles (2.79 lumens per square meter) shall be provided in any dining area, in any physical and restorative therapy area, and at any bathing facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain lighting for one of two resident bathing areas (memory care spa shower room). Findings include: 1. Observation on 8/30/24 at 8:20 a.m. revealed the spa shower room in the memory care unit had a domed light fixture over the shower and a four-foot fluorescent light fixture on the ceiling in the center of the room. One of the bulbs in the fluorescent fixture was not working. The overall lighting in the room did not then maintain the minimum 30 foot candles of lighting. Interview with maintenance technician D at the time of the	S1050	Flourescent Tube Lighting has been replaced by Maintenance Tech on 08/30/24.	08/30/24

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S1050	Continued From page 29 observations confirmed those conditions.	S1050		