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
	11048	A. BUILDING: _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW APARTMENTS ASSISTED LIVING	515 OHIO STREET WAKONDA, SD 57073

(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 complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 6/9/25. Area surveyed included unexpected resident death. Parkview Apartments Assisted Living was found not in compliance with the following requirements: S030 and S337.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event.	S 030	S 030 System correction: All nursing staff will be re-educated on the Assisted Living requirements for incident reporting and what incidents need to be reported to the State through the Facility Reporting Incidents (FRI) no later than 7/10/25 at the mandatory nurses meeting. Education will include information from the 2567, a review of the following updated/revised policies including; Incident Reporting & Investigation Policy updated 7/1/25 & How to Complete State Reporting Forms (FRIs) along with updates to the Nursing Quick Reference Book which were also updated/revised on 7/1/25. Corrected to individual nurses: On 5/16/25 RN D was provided education and corrective action due to RN D not following proper procedure during/after this incident that was investigated by Admin A, DON B and HR director. On 6/10/25 RN C was provided education and corrective action due to RN C not following proper procedure during/after this incident which as noted above was investigated by Admin A, DON B and HR director. RN C's corrective action was provided later due to issues with schedules and scheduling a time to meet with RN C. Monitoring of System: DON/MDS coordinator or designee will monitor/audit Assisted Living (ALF) incident reports to be sure a FRI has been completed if necessary and that it has been initiated in a timely manner. Audits will be completed 2x/wk x 4 wks, 1x/wk x 4 weeks and monthly x 6 months. Information will be reported to the QAPI team at monthly QAPI meetings by the DON, MDS coordinator or designee.	07/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland — TITLE: Administrator — (X6) DATE: 07/03/2025

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S 030	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on an anonymous complaint review, care record review, interview, observation, night nurse check list review, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified within the designated timeframe of a reportable incident for one of one closed care record (1) reviewed. Findings include: 1. Review of the 5/14/25 at 3:30 p.m. anonymous complaint submitted to the SD DOH regarding resident 1 revealed an unexpected death. The facility had not submitted a facility-reported incident (FRI) to the SD DOH related to the anonymous complaint. 2. Review of resident 1's closed care record revealed: *His admission date was 1/13/2017. *His diagnoses included paranoid schizophrenia, seizures, chronic hepatic failure, hypertension, hyperlipemia, hypothyroidism, iron deficiency anemia, chronic obstructive pulmonary disease, anxiety, insomnia, hypokalemia, and nicotine dependence. *His ordered medications included antipsychotic, seizure, respiratory, and blood pressure medications. *The 7/16/24 physician's order stated "ASSISTED LIVING (AL) CHECKS AT 1200A (midnight), 0200A (2:00 a.m.), and 0400A (4:00 a.m.) three times a day for AL Checks. *The 5/5/25 physician's order stated "Release the body to the funeral home. Time 0620 (6:20 a.m.). *The 5/1/25 through 5/5/25 treatment administration record (TAR) for assisted living checks at midnight, 2:00 a.m. and 4:00 a.m. had	S 030		

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S 030	Continued From page 2 been documented for all five nights indicating it had been completed. *The progress notes with the following dates revealed: -On 5/2/25 at 4:34 a.m.: "Skin note: Skin is clean, dry and intact. No skins [skin] issues noted. Will continue to monitor." -On 5/5/25 at 6:59 a.m. by registered nurse (RN) D: "Pt [patient] noted to not come out for cigarettes, Recorder checked on pt, upon entering room pt noted to be on the floor on [his] back in the kitchen, asystolic [no heartbeat], no rigor [rigor mortis] present et [and] blood in the mouth. POA [power of attorney] called, MD [medical doctor] called et notified. Order obtained to release the body to the mortuary." -On 5/5/25 at 10:01 a.m. by RN C: "At 0900 (9:00 a.m.) [name of funeral home] here to pick up decreased [deceased]." -There were no further entries in his progress notes regarding his condition from 5/2/25 after the 4:34 a.m. entry through the 5/5/25 at 6:59 a.m. entry. *The undated service plan revealed: -He needed some help with bathing at times. -He had seizures, took seizure medications, and was followed by [name of agency] for behavioral health. -He had cigarettes that were kept in the medication room. Nursing dispensed 10 cigarettes per day (1x per day). -The smoking assessment and policy were reviewed with him. -He smoked only in designated areas. Review of the provider's list of residents who were in the assisted living from 5/4/25 through 5/5/25 revealed there were five residents. Resident 1 was included in that list.	S 030		

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S 030	Continued From page 3 Interview on 6/9/25 at 9:15 a.m. with director of nursing (DON) B regarding if the incident of resident 1 had been reported to the SD DOH revealed she had not reported resident 1's unexpected death, but should have. Interview on 6/9/25 at 9:25 a.m. with RN C revealed: *She had been employed at the facility since 4/11/2019. *She worked the day shift from 6:00 a.m. until 6:30 p.m. *She was responsible for the long-term care (LTC) and the AL residents. *She would pass medications in the AL. *Residents from the AL would come to the LTC to get their medications. *If she didn't see a resident out to the LTC dining area she would send a CNA (certified nursing assistant) to check on the resident. *If an AL resident needed to contact a nurse or staff they would use a pendant worn around their necks. *She knew resident 1 had a pendant and was able to use it. *Resident 1 would come up to the nurses' station and get cigarettes between 3:00 a.m. and 5:00 a.m. He was given 5 cigarettes at those times. -At noon, he would get another 5 cigarettes. *He kept his own lighter. *On 5/4/25: -RN C was administering residents' medications between 5:00 p.m. and 6:00 p.m. -At 5:45 p.m., she noticed resident 1 was not out to the LTC dining room. "She wondered if he had overslept." --She sent CNA F to check on him. *CNA F went to resident 1's room, had "eyes on him", returned, and told her resident 1 had thrown up.	S 030		

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S 030	Continued From page 4 *RN C passed the information regarding resident 1 having thrown up at 6:00 p.m. to RN D during the change of shifts report. -She had finished the end of shift report with RN D at 6:20 p.m. *RN C stated, "As a nurse I would have checked on the resident who had thrown up, but [I] didn't since [CNA F] "had laid eyes on him." *She agreed there was no charting or documentation in resident 1's care record regarding his condition on 5/4/25 at 6:00 p.m. *It was something she usually would have charted on but had left at 6:30 p.m. without completing the documentation. *She came back to work on 5/5/25 at 6:00 a.m. *RN D was giving RN C end of shift report. *RN D said resident 1 had: -Not been down to get his cigarettes. -Told him [RN D] he had thrown up blood on 5/4/25 around 7:00 p.m. *RN D had asked resident 1 if he had cleaned it up, which resident 1 confirmed he had done. -He had commented to resident 1 "Do you think that was a wise choice?" *RN D asked RN C after report, "Do you want me to check on [resident's name]?" *RN C was visiting with a hospice nurse regarding another resident at the same time and told RN D to go check on resident 1. *RN D went to check on resident 1. He came back and said to RN C, "I need you to come with me." -She was trying to finish up report with the hospice nurse. *RN D said again, "I need you to come now." *RN C went with RN D to resident 1's room. -Resident 1 was laying on the floor in the dinette section, in a supine (back) position, with his right leg bent. --There was dried blood all over his face and	S 030		

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chest, and a small amount on the floor.
--RN C said, "He was deceased."
*RN D walked back to the nurses station with RN C and said:
-"I am so [explicit]."
-"I didn't take his vital signs, I didn't check on him."
*The night nurse and the night aide were responsible to check on the AL residents.
*CNA E had seen resident 1 go outside at 11:00 p.m. on 5/4/25 to have a cigarette. Otherwise no one had checked on him.
*On 5/5/25 at 7:00 a.m. RN C went to resident 1's room while RN D was making telephone calls to the family and the physician.
-The CNAs were already in resident 1's room getting him lifted up of the floor with a Hoyer lift (a mechanical lift and sling used to lift a person's full body).
-She went into his bathroom and there was a bloody towel in the shower, blood splatter on the floor by the toilet and on the wall.
---The blood was dried and bright red.
*RN C had:
-Talked to DON B regarding resident 1.
-Not documented on 5/4/25 regarding his throwing up before leaving the facility at the end of her shift.
-Asked DON B if she should back chart on resident 1
--DON B had told her that in the future, she needed to document what happened.
*She reported off to the nurse.
*No education was provided to the nurses and no disciplinary action was completed for anyone regarding resident 1.

Interview on 6/9/25 at 10:10 a.m. with RN D and administrator A regarding resident 1 revealed:
*He had requested administrator A be present

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during the interview.
*He had worked at the facility for almost five years as an RN.
-He always worked the night shift.
*The night shift hours were from 10:00 p.m. through 6:30 a.m.
-There was one nurse and one CNA on during the night shifts.
*He had come to work on 5/4/25. He had "clocked in" at 6:00 p.m. and went to the office to wait for the end of shift report.
*The residents were active after supper, some wore Wanderguards (wearable door alarming devices), and some were exit-seeking and self-transferring.
*RN C had reported resident 1 had not come down for supper because he had vomited.
-RN C had not reported resident 1 had thrown up blood.
-That information "had been reported to her by one of the CNAs."
*They finished up with the end of shift report, counted narcotics, and he started to "mitigate call lights" and get residents out of the dining room following the evening meal.
*RN D did not know if RN C had checked on resident 1 prior to her leaving the facility at the end of her shift.
*RN D couldn't remember if RN C had asked him to check on resident 1. He had thought the report of resident 1 having vomited was "Just a point of fact."
*Resident 1:
-Came down to the nursing area around 7:15 p.m. to 7:30 p.m. to get his medications.
-Told him he had thrown up blood.
*RN D asked resident 1 if he could look at it, resident 1 had said no, that he had cleaned it up.
-Resident 1's hygiene was not the greatest, he was independent, alert, and oriented.

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S 030	Continued From page 7 *RN D had not completed vital signs or an assessment on resident 1. *RN D had asked resident 1 how he felt and resident 1 responded better. -There was no obvious change in resident 1's cognition. -He was cold but "he was always cold." -His gait was normal. -"Nothing unusual, just threw up blood." *RN D did not see resident 1 the remainder of that shift *CNA E had seen resident 1 go outside to smoke around midnight, which was not uncommon for him. *From around 7:30 p.m. on 5/4/25 through 6:00 a.m. on 5/5/25 RN D had "not laid eyes on resident 1." *RN D agreed the physician's order for resident 1 was to have checked on resident 1 at midnight, 2:00 a.m. and 4:00 a.m. -RN D had not gone to the AL that night but should have. --RN D confirmed CNA E had not gone to the AL either. *At 6:00 a.m. during the change of shifts, RN C had come on duty. *RN D gave RN C his end of shift report, they counted medications (narcotics), he told RN C that resident 1 had not come down for his "smokes", which wasn't always uncommon for him. *Resident 1's service plan had recently been changed regarding his smoking. *RN C told him to take resident 1's cigarettes to his room. *He walked into resident 1's room: -Resident 1 was found lying on the floor in the kitchen on his back, his left leg was out, his right leg was curled, and his arms were by his side. -His pupils were fixed and dilated, and there was	S 030		

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no cardiac activity.
--On the counter was peanut butter, jelly, and bread.
*He went back to RN C and asked her to come to resident 1's room with him.
*They both went to resident 1's room.
*He verified resident 1's body was cool to the touch, there was no sign of rigor mortis, and he had not checked his blood pressure or pulse.
*If he found someone on the floor he typically would have done vital signs.
--There was no blood on the floor, there was a little blood in his mouth, there was no blood on his face or shoulder.
-In the bathroom was a wadded up washcloth in the shower with no visible blood.
-There were two pea-sized blood spots on the wall by the toilet.
*He returned to the nurses' station and called the physician and the family.
-RN C went outside to smoke and then returned to the medication cart to deal with a hospice patient and a hospice nurse.
*Resident 1's family was not sure which mortuary to use.
*He called DON B and social services director G regarding resident 1.
*Around 7:30 a.m. he finished his calls, and then asked RN C if she needed anything.
*He had called DON B right away and spoke with her by telephone at approximately 8:00 a.m.
*He confirmed he had falsified resident 1's care record by documenting he had completed nightly checks on him, and hadn't done that.
-That "had happened more than it should have, about 50/50 percent of the time."

Interview with administrator A at the above time during the above interview with RN D regarding the ongoing investigation of resident 1 revealed:

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S 030	Continued From page 9 *There was an ongoing investigation of that incident. *They had a plan of correction. *Moving forward, they were educating the staff to write down times when doing tasks and when finished with the tasks. *DON B had followed up on the incident and had verified it had occurred. *The nurses were reeducated on completing rounds with residents. Interview on 6/9/25 at 10:45 a.m. with administrator A and DON B regarding the above interviews regarding resident 1 revealed: *RN C should have completed an assessment and charted an assessment on resident 1 at the time it was reported to her that he had vomited. *DON B's expectations were for the nurses to do assessments and document. *RN D had not investigated the blood when it first happened, and should have. *RN C and D both fell short on assessing and following up regarding resident 1. *DON B agreed both RN C and RN D: -Should have checked on resident 1. -Should have completed vital signs, assessments, and documentation on his change in condition. -RN D should not have falsified resident 1's care record regarding completing nightly checks. *DON B had: *Completed an internal investigation. *Provided the investigation to HR (human resources). *Reached out to RN D, met with him the following week, provided disciplinary action, and reeducation on how to complete rounds. *DON B's expectations were for the staff to complete the rounds on residents. *They had not completed an incident report.	S 030		

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S 030	Continued From page 10 *They had not reported the incident to the SD DOH. "In hindsight, we should have." *DON B would have expected RN D after having found resident 1 on the floor to have checked his vital signs and auscultated for his pulse when verifying the resident's condition (death). Observation on 6/9/25 at 11:10 a.m. of resident 1's previous apartment with DON B revealed no areas of blood. Review of the provider's revised May 2019 Reporting Requirements policy revealed: *Purpose: -"A. to report to the Department of Health (DOH) pertinent information regarding reportable events as defined by 44:70:01:07." *Policy" -"A. The DOH shall be notified within 48 hours of the event any death resulting from other than by natural causes originating on the facility property such as accidents, abuse, negligence or suicide; any missing residents; and allegations of abuse or neglect of a resident by any person. -An investigation of the event(s) shall be completed and the results submitted to the DOH within five working days of the event." Refer to S337, finding 1. .	S 030		

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S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on an anonymous complaint submitted to the South Dakota Department of Health (SD DOH), care record review, interview, observation, night nurse check list, policy review, and job description review, the provider failed to follow standards of practice to ensure: *Two of two registered nurses (RN) (C and D) had completed ongoing assessment and documentation for one of one closed sampled resident (1) care record reviewed, who had a change in condition. *One of one RN (D) had assessed the condition of a resident (1) before declaring death. *One of one RN (D) had not falsified documentation in one of one closed sampled resident's care record (1), who had a change in condition. Findings include: 1. Review of the 5/14/25 at 3:30 p.m. anonymous complaint submitted to the SD DOH regarding resident 1 revealed an unexpected death. The facility had not submitted a facility-reported incident (FRI) to the SD DOH regarding the anonymous complaint. 2. Review of resident 1's closed care record revealed:	S 337	S 337 System Correction: Nurses' meeting is scheduled for 7/10/25 and all nurses will be educated before or by 7/10/25 in all areas of care policies, standards of professional practice, ethics and change of condition/ assessments. Education will include updated/revised policies, forms and evaluation tools that were updated by 7/1/25. These include; Nursing Professional Standards in Long-Term Care Policy, Acute Care Monitoring/ Change of Condition Policy with attached SBAR report form, Assisted Living Resident Evaluation Tool (which includes wellness check preference and a section on education about the call light system & call pendant), Death/Death Pronouncement Policy with death of a resident checklist added, Documentation in Medical Record (including downtime) Policy, 24 Hour Emergency Response Policy, Staffing for Parkview Assisted Living Policy along with other items noted under system correction system of S 030 will all be addressed at the Nurses' meeting or before if someone is unable to attend. Corrected to Individuals: All current AL residents have been re-educated on their call light system in their apartments and their call pendant that they wear. They have also been asked about their preferences for wellness checks and these preferences have been added to their individual service/care plans. If resident requests to have wellness checks, the times requested are put in the electronic medical record (EMR). Monitoring of System: DON or designee will receive report from charge nurse on all AL residents and will review documentation in EMR to ensure adequate documentation and assessment has been completed for any change in condition. These audits will be completed 3-5x/week x 4 weeks, 2x/week x 4 weeks, 1x/wk x 4 weeks and then monthly x 3 months. DON or designee will also monitor documentation for all deaths x 6 months. DON or designee will report all information to QAPI team at monthly QAPI meeting.	07/10/2025

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	11048	A. BUILDING: _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW APARTMENTS ASSISTED LIVING	515 OHIO STREET WAKONDA, SD 57073

(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
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*His admission date was 1/13/2017.
*His diagnoses included paranoid schizophrenia, seizures, chronic hepatic failure, hypertension, hyperlipemia, hypothyroidism, iron deficiency anemia, chronic obstructive pulmonary disease, anxiety, insomnia, hypokalemia, and nicotine dependence.
*His ordered medications included antipsychotic, seizure, respiratory, and blood pressure medications.
*The 7/16/24 physician's order stated "ASSISTED LIVING (AL) CHECKS AT 1200A (midnight), 0200A (2:00 a.m.), and 0400A (4:00 a.m.) three times a day for AL Checks.
*The 5/5/25 physician's order stated "Release the body to the funeral home. Time 0620 (6:20 a.m.).
*The 5/1/25 through 5/5/25 treatment administration record (TAR) for assisted living checks at midnight, 2:00 a.m. and 4:00 a.m. had been documented for all five nights indicating it had been completed.
*The progress notes with the following dates revealed:
-On 5/2/25 at 4:34 a.m.: "Skin note: Skin is clean, dry and intact. No skins [skin] issues noted. Will continue to monitor."
-On 5/5/25 at 6:59 a.m. by registered nurse (RN) D: "Pt [patient] noted to not come out for cigarettes, Recorder checked on pt, upon entering room pt noted to be on the floor on [his] back in the kitchen, asystolic [no heartbeat], no rigor [rigor mortis] present et [and] blood in the mouth. POA [power of attorney] called, MD [medical doctor] called et notified. Order obtained to release the body to the mortuary."
-On 5/5/25 at 10:01 a.m. by RN C: "At 0900 (9:00 a.m.) [name of funeral home] here to pick up decreased [deceased]."
-There were no further entries in his progress notes regarding his condition from 5/2/25 after

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S 337	Continued From page 13 the 4:34 a.m. entry through the 5/5/25 at 6:59 a.m. entry. *The undated service plan revealed: -He needed some help with bathing at times. -He had seizures, took seizure medications, and was followed by [name of agency] for behavioral health. -He had cigarettes that were kept in the medication room. Nursing dispensed 10 cigarettes per day (1x per day). -The smoking assessment and policy were reviewed with him. -He smoked only in designated areas. Review of the provider's list of residents who were in the assisted living from 5/4/25 through 5/5/25 revealed there were five residents. Resident 1 was included in that list. Interview on 6/9/25 at 9:15 a.m. with director of nursing (DON) B regarding if the incident of resident 1 had been reported to the SD DOH revealed she had not reported resident 1's unexpected death, but should have. Interview on 6/9/25 at 9:25 a.m. with RN C revealed: *She had been employed at the facility since 4/11/2019. *She worked the day shift from 6:00 a.m. until 6:30 p.m. *She was responsible for the long-term care (LTC) and the AL residents. *She would pass medications in the AL. *Residents from the AL would come to the LTC to get their medications. *If she didn't see a resident out to the LTC dining area she would send a CNA (certified nursing assistant) to check on the resident. *If an AL resident needed to contact a nurse or	S 337	S 337 System Correction: Nurses' meeting is scheduled for 7/10/25 and all nurses will be educated before or by 7/10/25 in all areas of care policies, standards of professional practice, ethics and change of condition/ assessments. Education will include updated/revised policies, forms and evaluation tools that were updated by 7/1/25. These include; Nursing Professional Standards in Long-Term Care Policy, Acute Care Monitoring/Change of Condition Policy with attached SBAR report form, Assisted Living Resident Evaluation Tool (which includes wellness check preference section and a section on education about the call light system & call pendant), Death/Death Pronouncement Policy with death of a resident checklist added, Documentation in Medical Record (including downtime) Policy, 24 Hour Emergency Response Policy, Staffing for Parkview Assisted Living Policy along with other items noted under system correction system of S 030 will all be addressed at the Nurses' meeting or before if someone is unable to attend. Corrected to Individuals: All currrent AL residents have been re-educated on their call light system in their apartments and their call pendant that they wear. They have also been asked about their preference for wellness checks and these preferences have been added to their individual service/care plans. If resident requests to have wellness checks, the times requested are put in the electronic medical record (EMR). Monitoring of System: DON or designee will receive report from charge nurse on all AL residents and will review documentation in EMR to ensure adequate documentation and assessment has been completed for any change in condition. These audits will be completed 3-5x/week x 4 weeks, 2x/week x 4 weeks, 1x/wk x 4 weeks and then monthly x 3 months. DON or designee will also monitor documentation for all deaths x 6 month	

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staff they would use a pendant worn around their necks.
*She knew resident 1 had a pendant and was able to use it.
*Resident 1 would come up to the nurses' station and get cigarettes between 3:00 a.m. and 5:00 a.m. He was given 5 cigarettes at those times.
-At noon, he would get another 5 cigarettes.
*He kept his own lighter.
*On 5/4/25:
-RN C was administering residents' medications between 5:00 p.m. and 6:00 p.m.
-At 5:45 p.m., she noticed resident 1 was not out to the LTC dining room. "She wondered if he had overslept."
--She sent CNA F to check on him.
*CNA F went to resident 1's room, had "eyes on him", returned, and told her resident 1 had thrown up.
*RN C passed the information regarding resident 1 having thrown up at 6:00 p.m. to RN D during the change of shifts report.
-She had finished the end of shift report with RN D at 6:20 p.m.
*RN C stated, "As a nurse I would have checked on the resident who had thrown up, but [I] didn't since [CNA F] "had laid eyes on him."
*She agreed there was no charting or documentation in resident 1's care record regarding his condition on 5/4/25 at 6:00 p.m.
*It was something she usually would have charted on but had left at 6:30 p.m. without completing the documentation.
*She came back to work on 5/5/25 at 6:00 a.m.
*RN D was giving RN C end of shift report.
*RN D said resident 1 had:
-Not been down to get his cigarettes.
-Told him [RN D] he had thrown up blood on 5/4/25 around 7:00 p.m.
*RN D had asked resident 1 if he had cleaned it

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S 337	Continued From page 15 up, which resident 1 confirmed he had done. -He had commented to resident 1 "Do you think that was a wise choice?" *RN D asked RN C after report, "Do you want me to check on [resident's name]?" *RN C was visiting with a hospice nurse regarding another resident at the same time and told RN D to go check on resident 1. *RN D went to check on resident 1. He came back and said to RN C, "I need you to come with me." -She was trying to finish up report with the hospice nurse. *RN D said again, "I need you to come now." *RN C went with RN D to resident 1's room. -Resident 1 was laying on the floor in the dinette section, in a supine (back) position, with his right leg bent. --There was dried blood all over his face and chest, and a small amount on the floor. --RN C said, "He was deceased." *RN D walked back to the nurses station with RN C and said: -"I am so [explicit]." -"I didn't take his vital signs, I didn't check on him." *The night nurse and the night aide were responsible to check on the AL residents. *CNA E had seen resident 1 go outside at 11:00 p.m. on 5/4/25 to have a cigarette. Otherwise no one had checked on him. *On 5/5/25 at 7:00 a.m. RN C went to resident 1's room while RN D was making telephone calls to the family and the physician. -The CNAs were already in resident 1's room getting him lifted up off the floor with a Hoyer lift (a mechanical lift and sling used to lift a person's full body). -She went into his bathroom and there was a bloody towel in the shower, blood splatter on the	S 337		

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floor by the toilet and on the wall.
---The blood was dried and bright red.
*RN C had:
-Talked to DON B regarding resident 1.
-Not documented on 5/4/25 regarding his throwing up before leaving the facility at the end of her shift.
-Asked DON B if she should back chart on resident 1
--DON B had told her that in the future, she needed to document what happened.
*She reported off to the nurse.
*No education was provided to the nurses and no disciplinary action was completed for anyone regarding resident 1.

Interview on 6/9/25 at 10:10 a.m. with RN D and administrator A regarding resident 1 revealed:
*He had requested administrator A be present during the interview.
*He had worked at the facility for almost five years as an RN.
-He always worked the night shift.
*The night shift hours were from 10:00 p.m. through 6:30 a.m.
-There was one nurse and one CNA on during the night shifts.
*He had come to work on 5/4/25. He had "clocked in" at 6:00 p.m. and went to the office to wait for the end of shift report.
*The residents were active after supper, some wore Wanderguards (wearable door alarming devices), and some were exit-seeking and self-transferring.
*RN C had reported resident 1 had not come down for supper because he had vomited.
-RN C had not reported resident 1 had thrown up blood.
-That information "had been reported to her by one of the CNAs."

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S 337	Continued From page 17 *They finished up with the end of shift report, counted narcotics, and he started to "mitigate call lights" and get residents out of the dining room following the evening meal. *He did not know if RN C had checked on resident 1 prior to her leaving the facility at the end of her shift. *He couldn't remember if RN C had asked him to check on resident 1. He had thought the report of resident 1 having vomited was "Just a point of fact." *Resident 1: -Came down to the nursing area around 7:15 p.m. to 7:30 p.m. to get his medications. -Told him (RN D) he had thrown up blood. *RN D asked resident 1 if he could look at it, resident 1 had said no, that he had cleaned it up. -Resident 1's hygiene was not the greatest, he was independent, alert, and oriented. *RN D had not completed vital signs or an assessment on resident 1. *RN D had asked resident 1 how he felt and resident 1 responded better. -There was no obvious change in resident 1's cognition. -He was cold but "he was always cold." -His gait was normal. -"Nothing unusual, just threw up blood." *RN D did not see resident 1 the remainder of that shift *CNA E had seen resident 1 go outside to smoke around midnight, which was not uncommon for him. *From around 7:30 p.m. on 5/4/25 through 6:00 a.m. on 5/5/25 RN D had "not laid eyes on resident 1." *He agreed the physician's order for resident 1 was to have checked on resident 1 at midnight, 2:00 a.m. and 4:00 a.m. -He had not gone to the AL that night but should	S 337		

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have.
--He confirmed CNA E had not gone to the AL either.
*At 6:00 a.m. during the change of shifts, RN C had come on duty.
*He gave RN C his end of shift report, they counted medications (narcotics), he told RN C that resident 1 had not come down for his "smokes", which wasn't always uncommon for him.
*Resident 1's service plan had recently been changed regarding his smoking.
*RN C told him to take resident 1's cigarettes to his room.
*He walked into resident 1's room:
-Resident 1 was found lying on the floor in the kitchen on his back, his left leg was out, his right leg was curled, and his arms were by his side.
-His pupils were fixed and dilated, and there was no cardiac activity.
--On the counter was peanut butter, jelly, and bread.
*He went back to RN C and asked her to come to resident 1's room with him.
*They both went to resident 1's room.
*He verified resident 1's body was cool to the touch, there was no sign of rigor mortis, and he had not checked his blood pressure or pulse.
*If he found someone on the floor he typically would have done vital signs.
--There was no blood on the floor, there was a little blood in his mouth, there was no blood on his face or shoulder.
-In the bathroom was a wadded up washcloth in the shower with no visible blood.
-There were two pea-sized blood spots on the wall by the toilet.
*He returned to the nurses' station and called the physician and the family.
-RN C went outside to smoke and then returned

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S 337	Continued From page 19 to the medication cart to deal with a hospice patient and a hospice nurse. *Resident 1's family was not sure which mortuary to use. *He called DON B and social services director G regarding resident 1. *Around 7:30 a.m. he finished his calls, and then asked RN C if she needed anything. *He had called DON B right away and spoke with her by telephone at approximately 8:00 a.m. *He confirmed he had falsified resident 1's care record by documenting he had completed nightly checks on him, and hadn't done that. -That "had happened more than it should have, about 50/50 percent of the time." Interview with administrator A at the above time during the above interview with RN D regarding the ongoing investigation of resident 1 revealed: *There was an ongoing investigation of that incident. *They had a plan of correction. *Moving forward, they were educating the staff to write down times when doing tasks and when finished with the tasks. *DON B had followed up on the incident and had verified it had occurred. *The nurses were reeducated on completing rounds with residents. Interview on 6/9/25 at 10:45 a.m. with administrator A and DON B regarding the above interviews regarding resident 1 revealed: *RN C should have completed an assessment and charted an assessment on resident 1 at the time it was reported to her that he had vomited. *DON B's expectations were for the nurses to do assessments and document. *RN D had not investigated the blood when it first happened, and should have.	S 337		

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*RN C and D both fell short on assessing and following up regarding resident 1.
*DON B agreed both RN C and RN D:
-Should have checked on resident 1.
-Should have completed vital signs, assessments, and documentation on his change in condition.
-RN D should not have falsified resident 1's care record regarding completing nightly checks.
*DON B had:
*Completed an internal investigation.
*Provided the investigation to HR (human resources).
*Reached out to RN D, met with him the following week, provided disciplinary action, and reeducation on how to complete rounds.
*DON B's expectations were for the staff to complete the rounds on residents.
*They had not completed an incident report.
*They had not reported the incident to the SD DOH. "In hindsight, we should have."
*DON B would have expected RN D after having found resident 1 on the floor to have checked his vital signs and auscultated for his pulse when verifying the resident's condition (death).

Observation on 6/9/25 at 11:10 a.m. of resident 1's previous apartment with DON B revealed no areas of blood.

Review of the provider's revised May 2019 Reporting Requirements policy revealed:
*Purpose:
-"A. to report to the Department of Health (DOH) pertinent information regarding reportable events as defined by 44:70:01:07."
*Policy"
-"A. The DOH shall be notified within 48 hours of the event any death resulting from other than by natural causes originating on the facility property

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S 337	Continued From page 21 such as accidents, abuse, negligence or suicide; any missing residents; and allegations of abuse or neglect of a resident by any person. -An investigation of the event(s) shall be completed and the results submitted to the DOH within five working days of the event." Review of the provider's undated Night Nurse Checklist revealed: *"All nurse[s] are required to complete these duties - including agency!" *"*****Check assisted living Q2hrs (every two hours)." *"*****Breath checks on all residents Q2hrs." Review of the provider's June 2022 Documentation in Medical Records (Including Downtime) policy revealed: *Objective: -"1. To establish a means of communication between patient care providers. -2. To establish a standard of practice for documentation for all nursing staff. -3. To provide a legal recording of patient experiences, while under the care of health care providers at [name of facility]." *Documentation in the Electronic Medical Record (care record): -"1. Nurses shall add and document on the appropriate interventions, based upon patient [resident]-specific frequencies. -2. Other interventions are completed in relation to physician's orders or other findings during the physical assessment. -3. Nurses are responsible to assure [ensure] all documentation is complete and accurate. -4. Real time documentation is encouraged. If unable to accomplish real time documentation, nurses will back time accordingly."	S 337		

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S 337	Continued From page 22 Review of the provider's April 2019 Notification of Changes policy revealed: *Purpose: -"A. to involve the resident, family and/or responsible party and physician in the resident's care. -B. To notify the resident, family and/or responsible party of changes in the resident's condition, plan of care, or medications of an accident." *Policy: -"A. It is the responsibility of the Charge Nurse to notify the resident of changes in:" --"2. The Charge Nurse will notify the physician: ---b. Of any significant change in the resident's physical, mental, or psychological status (e.g. deterioration in health, mental or psychological status in either life threatening condition or clinical complications). ---c. Of a need to alter treatment due to adverse consequences or to commence a new form of treatment." Review of the provider's September 2024 Fall Response policy revealed: *Policy: -"Each resident is fully assessed by the Charge Nurse immediately after any event that is considered a fall. Appropriate documentation is completed in the EMR (electronic medical record)." *Procedure: -"1. Do not move resident until assessed by the Charge Nurse. -2. Check the patient's [resident] breathing, pulse, and blood pressure." Review of the provider's May 2013 Director of Nursing Home Administrator job description revealed:	S 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11048	A. BUILDING: _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 337	Continued From page 23 *"Responsible to plan, organize and direct all aspects of [name of facility] in accordance with the philosophy of the [name of organization] and consistent with State and Joint Commission standards. -Coordinates the activities of all departments in providing care that meets the spiritual, emotional, and social needs of those served by the community." Review of the provider's undated Director of Nursing Service job description revealed: *Job Summary: -"A. The Director of Nursing is directly responsible to the Administrator and shall provide a high standard of care within sound economic guidelines to residents by planning, directing, delegating, implementing, coordinating, and evaluating care delivery and personnel giving the care." Review of the provider's undated Registered Nurse job description revealed: *V. Work Performed: -"B. Makes nursing assessments regarding the health status of [the] resident and is knowledgeable of the resident's condition at all times and reports pertinent changes to [the resident's] family, physician and [the] Director of Nursing. -C. Makes nursing diagnosis which serves as the basis for strategy of care. -D. Develops plan of care based on assessment and nursing diagnosis. -E. Implements the nursing care of each resident assigning the nursing care of each resident to other nursing personnel in accordance with the resident's needs and the preparation and competence of nursing available. -F. Supervises and evaluates the resident's	S 337		

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 337	Continued From page 24 response to nursing interventions. -H. documents in the medical record information that reflect the entire nursing assessment, diagnosis, plan, implementation and evaluation. -I. Documents in the medical record information that reflects and change in condition or behavior of the resident. Documents information a minimum of once a month." Review of the provider's undated Certified Nursing Assistant job description revealed "Delivery of nursing care which has been delegated by a Licensee."	S 337		