South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B WING 06/09/2025 11048 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **515 OHIO STREET** PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 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. 07/10/2025 S 030 S 030 44:70:01:07 Reports To The Department System correction: All nursing staff will be re-educated on the Assisted Living requirements for incident Each facility shall report the following events to reporting and what incidents need to be reported to the State through the Facility Reporting Incidents (FRI) the department through the department's online no later than 7/10/25 at the mandatory nurses meeting reporting system within twenty-four hours of the Education will include information from the 2567, a discovery of the event: review of the following updated/revised policies including: Incident Reporting & Investigation Policy updated 7/1/25 & How to Complete State Reporting (1) An attempted suicide; Forms (FRIs) along with updates to the Nursing Quick Reference Book which were also updated/revised on (2) Any cause to suspect abuse or neglect of a resident: Corrected to individual nurses: On 5/16/25 RN D was (3) Any death resulting from other than natural provided education and corrective action due to RN D causes that originated on facility property; not following proper procedure during/after this incident that was investigated by Admin A, DON B (4) A missing resident; and HR director. (5) A fire in the facility; On 6/10/25 RN C was provided education and (6) Any loss of utilities, emergency generator, fire corrective action due to RN C not following proper procedure during/after this incident which as noted alarm, sprinklers, and other critical equipment above was investigated by Admin A, DON B and HR necessary for operation of the facility for more director. RN C's corrective action was provided later due to issues with schedules and scheduling a time to than twenty-four hours; or meet with RN C. (7) Any unsafe drinking water samples, or samples from pools or spas. Monitoring of System: DON/MDS coordinator or designee will monitor/audit Assisted Living (ALF) incident reports to be sure a FRI has been completed The facility shall conduct an internal investigation if necessary and that it has been initiated in a timely manner. Audits will be completed 2x/wk x 4 wks, for the event and report the results to the 1x/wk x 4 weeks and monthly x 6 months. Information will be reported to the QAPI team at monthly QAPI department no later than five working days after meetings by the DON, MDS coordinator or designee. the event. The department may request additional information from the facility and investigate any reported event.

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

Robin R. Stockland

TITLE

(X6) DATE

Administrator

07/03/2025

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X = X = 2 = 2 = 2 | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| PARKVIEW / | APARTMENTS ASSIST | ED LIVING WAKONDA | | | | |
| (X4) ID | SLIMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | COMPLETE DATE |
| S 030 | Continued From page | 1 | S 030 | | | |
| n E n c c fill d c F 1 c c n * * * * * * * * * * * * * * * * * | net as evidenced by: Based on an anonymer ecord review, interview check list review, and ailed to ensure the Schealth (SD DOH) had designated timeframe one of one closed care findings include: I. Review of the 5/14/ complaint submitted to esident 1 revealed an acility had not submit ncident (FRI) to the School to the School anonymous complaint 2. Review of resident evealed: His admission date well- esizures, chronic hep- phyperlipemia, hypothy anemia, chronic obstranxiety, insomnia, hyp dependence. His ordered medications esizure, respiratory, an edications. The 7/16/24 physician LIVING (AL) CHECKS 20200A (2:00 a.m.), an imes a day for AL Che The 5/5/25 physician body to the funeral ho or the 5/1/25 through 5 dedministration record | ous complaint review, care ew, observation, night nurse policy review, the provider outh Dakota Department of I been notified within the of a reportable incident for e record (1) reviewed. (25 at 3:30 p.m. anonymous to the SD DOH regarding nunexpected death. The sted a facility-reported SD DOH related to the t. (1's closed care record was 1/13/2017. The paranoid schizophrenia, atic failure, hypertension, proidism, iron deficiency ructive pulmonary disease, pokalemia, and nicotine for sorder stated "ASSISTED SAT 1200A (midnight), and 0400A (4:00 a.m.) three tecks. (a)'s order stated "Release the ome. Time 0620 (6:20 a.m.). | | | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
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| PARKVIEV | N APARTMENTS ASSIST | ED LIVING WAKONDA | , SD 57073 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| S 030 | Continued From page | 2 | S 030 | | | |
| S 030 | been documented for had been completed. *The progress notes or revealed: -On 5/2/25 at 4:34 a.r. dry and intact. No skin continue to monitor." -On 5/5/25 at 6:59 a.r. D: "Pt [patient] noted cigarettes, Recorder centering room pt note back in the kitchen, arigor [rigor mortis] premouth. POA [power of [medical doctor] called to release the body to -On 5/5/25 at 10:01 at a.m.) [name of funeral decreased [deceased -There were no further notes regarding his content of the 4:34 a.m. entry that a.m. entry. *The undated service -He needed some hell -He had seizures, too | all five nights indicating it with the following dates m.: "Skin note: Skin is clean, ns [skin] issues noted. Will m. by registered nurse (RN) to not come out for checked on pt, upon d to be on the floor on [his] systolic [no heartbeat], no esent et [and] blood in the f attorney] called, MD d et notified. Order obtained the mortuary." .m. by RN C: "At 0900 (9:00 al home] here to pick up all." er entries in his progress condition from 5/2/25 after rough the 5/5/25 at 6:59 plan revealed: p with bathing at times. k seizure medications, and the of agency] for behavioral at were kept in the resing dispensed 10 at per day). | S 030 | | | |
| | -He smoked only in de | esignated areas. | | | | |
| | | | | | | |

PRINTED: 06/24/2025 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WNG 06/09/2025 11048 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 OHIO STREET** PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) S 030 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 *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:

overslept."

up.

-RN C was administering residents' medications

-At 5:45 p.m., she noticed resident 1 was not out to the LTC dining room. "She wondered if he had

*CNA F went to resident 1's room, had "eves on him", returned, and told her resident 1 had thrown

between 5:00 p.m. and 6:00 p.m.

-- She sent CNA F to check on him.

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 2 2 | CONSTRUCTION | (X3) DATE S COMPLE | |
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| PARKVIEV | N APARTMENTS ASSIST | WAKONDA | A, SD 57073 | | | |
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| S 030 | *RN C passed the inf 1 having thrown up at the change of shifts in -She had finished the D at 6:20 p.m. *RN C stated, "As a r on the resident who h since [CNA F] "had la *She agreed there wa documentation in res regarding his conditio *It was something sho on but had left at 6:30 the documentation. *She came back to w *RN D was giving RN *RN D said resident 1 -Not been down to ge -Told him [RN D] he h 5/4/25 around 7:00 p. *RN D had asked res up, which resident 1 -He had commented that was a wise choic *RN D asked RN C a to check on [resident" | formation regarding resident t 6:00 p.m. to RN D during eport. e end of shift report with RN nurse I would have checked had thrown up, but [I] didn't hid eyes on him." has no charting or hident 1's care record ho non 5/4/25 at 6:00 p.m. he usually would have charted to p.m. without completing fork on 5/5/25 at 6:00 a.m. I C end of shift report. I had: hat his cigarettes. had thrown up blood on h.m. hident 1 if he had cleaned it confirmed he had done. to resident 1 "Do you think he?" fter report, "Do you want me s's name]?" | S 030 | | | |
| | another resident at the to go check on reside | | | | | |
| | | on resident 1. He came C, "I need you to come with | | · · | | |
| | hospice nurse. *RN D said again, "I r *RN C went with RN | ish up report with the need you to come now." D to resident 1's room. ng on the floor in the dinette | | | | |
| п | | back) position, with his right | | | | |

-- There was dried blood all over his face and

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | NOTE DESCRIPTION OF THE PROPERTY OF THE PROPER | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | C and said: -"I am so [explicit]." -"I didn't take his vital him." *The night nurse and responsible to check to the control on | deceased." In the nurses station with RN signs, I didn't check on the night aide were on the AL residents. Ident 1 go outside at 11:00 e a cigarette. Otherwise no nim. In. RN C went to resident 1's making telephone calls to visician. ady in resident 1's room of the floor with a Hoyer lift (a | | | | |
| | 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. | | | | | |

*He had requested administrator A be present

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| DA DIZVIEV | N ADADTMENTS ASSIST | 515 OHIO S | TREET | | | |
| PARKVIEV | V APARTMENTS ASSIST | ED LIVING WAKONDA | , SD 57073 | | | |
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| S 030 | Continued From page | 6 | S 030 | | | |
| S 030 | during the interview. *He had worked at the years as an RNHe always worked th *The night shift hours through 6:30 a.mThere was one nurse night shifts. *He had come to work "clocked in" at 6:00 p. wait for the end of shi *The residents were a wore Wanderguards (devices), and some with self-transferring. *RN C had reported redown for supper becated and the control of the CNAs." *They finished up with counted narcotics, and lights" and get resident following the evening *RN D did not know if resident 1 prior to here and of her shift. *RN D couldn't rement to check on resident 1 for resident 1 having vifact." *Resident 1: | e facility for almost five e night shift. were from 10:00 p.m. e and one CNA on during the c on 5/4/25. He had m. and went to the office to fit report. active after supper, some (wearable door alarming vere exit-seeking and esident 1 had not come huse he had vomited. ed resident 1 had thrown up d been reported to her by in the end of shift report, d he started to "mitigate call ints out of the dining room meal. FRN C had checked on leaving the facility at the inber if RN C had asked him l. He had thought the report omited was "Just a point of | S 030 | | | |
| 3 | p.m. to 7:30 p.m. to g -Told him he had throw *RN D asked resident resident 1 had said no | wn up blood. 1 if he could look at it, 5, that he had cleaned it up. | | | | |
| | -Resident 1's hygiene was independent, ale | was not the greatest, he rt, and oriented. | | | | |

| South Da | akota Department of He | ealth | | | | |
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| PARKVIE | N APARTMENTS ASSIST | ED LIVING | DA, SD 57073 | | | |
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| S 030 | Continued From page | 7 | S 030 | | | |
| 5 030 | *RN D had not complete assessment on resided *RN D had asked resiresident 1 responded -There was no obvious cognition. -He was cold but "he was normal. -"Nothing unusual, just *RN D did not see resithat shift *CNA E had seen resident around midnight, which him. *From around 7:30 p. a.m. on 5/5/25 RN D b resident 1." *RN D agreed the phy was to have checked 2:00 a.m. and 4:00 a.mRN D had not gone to should have. RN D confirmed CN either. *At 6:00 a.m. during the had come on duty. *RN D gave RN C his counted medications (that resident 1 had no "smokes", which was him. *Resident 1's service changed regarding his *RN C told him to take his room. | eted vital signs or an ent 1. dent 1 how he felt and better. s change in resident 1's was always cold." It threw up blood." ident 1 go outside to smoke the was not uncommon for m. on 5/4/25 through 6:00 and "not laid eyes on resident 1 at midnight, m. of the AL that night but A E had not gone to the AL the change of shifts, RN C end of shift report, they (narcotics), he told RN C to come down for his of talways uncommon for plan had recently been a smoking. The resident 1's cigarettes to | \$ 030 | | | |
| | kitchen on his back, hi leg was curled, and hi | ent 1's room: I lying on the floor in the is left leg was out, his right s arms were by his side. and dilated, and there was | | | | |

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - Committee Comm | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | | |
| DA DKV/IEV | N APARTMENTS ASSIST | STED LIVING 515 OHIO S | STREET | | | | |
| PARKVIEV | W APARTMENTS ASSIST | WAKONDA | , SD 57073 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| | bread. *He went back to RN resident 1's room with *They both went to re *He verified resident touch, there was no shad not checked his land not checked his | esident 1's room. 1's body was cool to the sign of rigor mortis, and he blood pressure or pulse. on the floor he typically I signs. I on the floor, there was a th, there was no blood on his | | | | | |
| | wall by the toilet. *He returned to the n physician and the fan -RN C went outside to to the medication car patient and a hospice *Resident 1's family v to use. *He called DON B an regarding resident 1. *Around 7:30 a.m. he asked RN C if she ne *He had called DON her by telephone at a *He confirmed he had record by documentir checks on him, and h -That "had happened about 50/50 percent of | urses' station and called the nily. o smoke and then returned to deal with a hospice enurse. was not sure which mortuary discould service director Grainshed his calls, and then reded anything. Bright away and spoke with approximately 8:00 a.m. displaying the had completed nightly readn't done that. | | | | | |

the ongoing investigation of resident 1 revealed:

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 52 52 | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| A STATE OF S | , SETTI TOTAL TOTAL TAIL | A. BUILDING: _ | | 99.0 | |
| | 11048 | B. WING | | 06/09 | 9/2025 |
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| PARKVIEW APARTMENTS ASSIST | ED LIVING 515 OHIO S | TREET | | | |
| TARREST AFARTMENTS ASSIST | WAKONDA | , SD 57073 | | | |
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| S 030 Continued From page | 9 | S 030 | | | |
| *There was an ongoir incident. *They had a plan of complete the second regarding completed an intermination of the second regarding completed an intermination. *There was an ongoir incident. *They had a plan of completed with the tasks and continuous with residents. Interview in 6/9/25 at administrator A and Doministrator A and Doministrato | orrection. If were educating the staff to a doing tasks and when a up on the incident and had a d. If were educating the staff to a doing tasks and when a up on the incident and had a d. If were educating the and had a d. If were for the above esident 1 revealed: If were for the nurses to do a swere | | | | |

*They had not completed an incident report.

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FORM APPROVED South Dakota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING 06/09/2025 11048 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 030 Continued From page 10 S 030 *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.

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| | | 11048 | D. WING | | 06/0 | 9/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE. ZIP CODE | | |
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| PARKVIEV | W APARTMENTS ASSIST | ED LIVING 515 OHIO S | | | | |
| | | WAKONDA | , SD 57073 | | | |
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| S 337 | Continued From page | 11 | S 337 | | | |
| | | | S-00-6-568 | | | |
| S 337 | 44:70:04:11 Care Poli | icies | S 337 | S 337 | | 07/10/2025 |
| | | | | System Correction: Nurses' meeting is schedule | | |
| | Each facility shall esta | ablish and maintain policies, | | 7/10/25 and all nurses will be educated before | | |
| | | tices that follow accepted | | 7/10/25 in all areas of care policies, standards of | | |
| | | onal practice to govern care, | | professional practice, ethics and change of con | | |
| | | or other services necessary | | assessments. Education will include updated/repolicies, forms and evaluation tools that were updated. | | |
| | to meet the residents' | pri - un successi gradi - comencia i sissi anche come con | | by 7/1/25. These include; Nursing Professional | Participation of Cappary | |
| | to meet the residents | needs. | | in Long-Term Care Policy, Acute Care Monitorin | | |
| | | | | Change of Condition Policy with attached SBAI | | |
| | | | | form, Assisted Living Resident Evaluation Tool | | |
| | This Administrative Rule of South Dakota is not | | | includes wellness check preference and a section | | |
| | met as evidenced by: | | | education about the call light system & call per | | |
| | | ous complaint submitted to | | Death/Death Pronouncement Policy with deat | | |
| | the South Dakota Dep | partment of Health (SD | | resident checklist added, Documentation in Me | | |
| | DOH), care record rev | view, interview, observation, | | Record (including downtime) Policy, 24 Hour E Response Policy, Staffing for Parkview Assisted | | |
| | night nurse check list, | policy review, and job | | Policy along with other items noted under syst | em | |
| | description review, the | e provider failed to follow | | correction system of S 030 will all be addressed | | |
| | standards of practice | to ensure: | | Nurses' meeting or before if someone is unable | | |
| | | d nurses (RN) (C and D) | | attend. | | |
| | had completed ongoir | | | Corrected to Individuals: All current AL residen | te baye | |
| | | e of one closed sampled | | been re-educated on their call light system in t | | |
| | | rd reviewed, who had a | | apartments and their call pendant that they we | | |
| | change in condition. | | | have also been asked about their preferences f | or | |
| | | ad assessed the condition | | wellness checks and these preferences have be | en added | |
| | of a resident (1) befor | | | to their individual service/care plans. If residen | | |
| | *One of one RN (D) h | | | to have wellness checks, the times requested a | re put in | |
| | | of one closed sampled | | the electronic medical record (EMR). | | . 4 |
| | | | | Monitoring of System: DON or designee will re- | | |
| | condition. | (1), who had a change in | | report from charge nurse on all AL residents ar | | |
| | | | | review documentation in EMR to ensure adequ | | |
| | Findings include: | | | documentation and assessment has been com any change in condition. These audits will be c | Manager and Control of the Control o | |
| | | | | 3-5x/week x 4 weeks, 2x/week x 4 weeks, 1x/w | | |
| | | /25 at 3:30 p.m. anonymous | | weeks and then monthly x 3 months. DON or d | | |
| | | o the SD DOH regarding | | will also monitor documentation for all deaths | | |
| | | n unexpected death. The | | months. DON or designee will report all inform | | |
| | facility had not submit | tted a facility-reported | | QAPI team at monthly QAPI meeting. | | |
| | incident (FRI) to the S | SD DOH regarding the | | | | |
| | anonymous complaint | | | | | |
| | | | | | | |
| | 2. Review of resident | 1's closed care record | | | | |
| | revealed: | | | | | |

PRINTED: 06/24/2025 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING 11048 06/09/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) S 337 S 337 Continued From page 12 *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

*The progress notes with the following dates

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

times a day for AL Checks.

had been completed.

*The 5/1/25 through 5/5/25 treatment

-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."

*The 5/5/25 physician's order stated "Release the body to the funeral home. Time 0620 (6:20 a.m.).

-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

| Paragraph Advances | T OF DEFICIENCIES | | (VO) MULTIPLE | CONSTRUCTION | T.,,,, - , | | |
|--------------------|--|--|---|--|----------------------------|------------------|--|
| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 0.000 | ECONSTRUCTION | (X3) DATE S | | |
| | | | A. BUILDING: | | | E-100071 E-1 | |
| | | E70007803460 | | | | | |
| | | 11048 | B. WING | | 06/0 | 9/2025 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | ATE, ZIP CODE | | | |
| | | 515 OHIO | | | | | |
| PARKVIE | W APARTMENTS ASSIST | ED LIVING | A, SD 57073 | | | | |
| (VA) ID | CLIMMA DV ST | | | DDOWDEDIO DI AVIOTI DODDECTIONI | |) Smooth | |
| (X4) ID PREFIX | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE | |
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| | | | | DEFICIENCY) | | | |
| S 337 | Continued From page | 13 | S 337 | | | | |
| | the 4:34 a m. entry th | rough the 5/5/25 at 6:59 | | X In the second | | | |
| | a.m. entry. | rough the 5/5/25 at 6.59 | | S 337 System Correction: Nurses' meeting is sche | duled for | | |
| | *The undated service | plan revealed: | | 7/10/25 and all nurses will be educated before | ore or by | | |
| | | p with bathing at times. | | 7/10/25 in all areas of care policies, standar professional practice, ethics and change of | ds of | | |
| | | k seizure medications, and | 1 | assessments. Education will include update | ed/revised | | |
| | | e of agency] for behavioral | 1 | policies, forms and evaluation tools that were | e updated | | |
| | health. | | | by 7/1/25. These include; Nursing Professio Standards in Long-Term Care Policy, Acute | Care | | |
| | -He had cigarettes that | at were kept in the | | Monitoring/Change of Condition Policy with SBAR report form, Assisted Living Resident | attached Evaluation | | |
| | medication room. Nur | sing dispensed 10 | | Tool (which includes wellness check prefere | ence | | |
| | cigarettes per day (1x | | 1 | section and a section on education about the ca system & call pendant), Death/Death Pronounce | | | |
| | -The smoking assess | ment and policy were | | Policy with death of a resident checklist add | ed. | | |
| | reviewed with him. | | | Documentation in Medical Record (including Policy, 24 Hour Emergency Response Policy | g downtime) v. Staffing | | |
| | -He smoked only in de | esignated areas. | | for Parkview Assisted Living Policy along wi items noted under system correction system | th other of S 030 | | |
| | | r's list of residents who | | will all be addressed at the Nurses' meeting if someone is unable to attend. | or before | | |
| | | ving from 5/4/25 through | | | | | |
| | 5/5/25 revealed there | | | Corrected to Individuals: All currrent AL resibeen re-educated on their call light system in | | | |
| | Resident 1 was include | led in that list. | | apartments and their call pendant that they have also been asked about their preference | wear. They e for | | |
| | | 9:15 a.m. with director of | | wellness checks and these preferences hav- added to their individual service/care plans. | If resident | | |
| | | rding if the incident of | | requests to have wellness checks, the times are put in the electronic medical record (EM | requested | | |
| | | eported to the SD DOH | | | S | | |
| | revealed she had not | The state of the s | | Monitoring of System: DON or designee will report from charge nurse on all AL residents | receive | | |
| | unexpected death, bu | t snould have. | | review documentation in EMR to ensure add | equate | | |
| | Interview on 6/9/25 at | 9:25 a m with RN C | | documentation and assessment has been of for any change in condition. These audits with the condition of the | | | |
| | revealed: | o.20 d.m. with the O | | completed 3-5x/week x 4 weeks, 2x/week x | 4 weeks. | | |
| | | yed at the facility since | | 1x/wk x 4 weeks and then monthly x 3 mont or designee will also monitor documentation | | | |
| | 4/11/2019. | ,,, | | deaths x 6 month | | | |
| | | shift from 6:00 a.m. until | | | | | |
| | 6:30 p.m. | | | | | | |
| | | for the long-term care | | | | | |
| | (LTC) and the AL resid | | | | | | |
| | *She would pass med | | | | | | |
| | | L would come to the LTC to | | | | | |
| | get their medications. | | | | | | |
| | | sident out to the LTC dining | | | | | |
| | | a CNA (certified nursing | | | | | |
| | assistant) to check on | the resident. | Ti . | | | | |

*If an AL resident needed to contact a nurse or

| AND BLAN OF CORRECTION IDENTIFICATION NUMBERS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 25000000 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | COMPLETED | |
|--|--|--|---------------|--|---|-----------|-----------|
| | | | 17.00000100-0 | 207291110000000000 | | С | |
| | | 11048 | B. W | B. WING | | - No. | 9/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | STRE | ET ADDRESS, | CITY, STAT | TE. ZIP CODE | | |
| | | 515 (| OHIO STREE | | | | |
| PARKVIE | W APARTMENTS ASSIST | TED LIVING WAK | ONDA, SD | 57073 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
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| S 337 | Continued From page | e 14 | S 3 | 37 | | | |
| | | a pendant worn around their | | | | | |
| | necks. | a pendant worn around their | | | | | |
| | I THE SECTION AND ADDRESS OF THE PARTY OF TH | had a pendant and was | | | | | |
| | able to use it. | | | | | | |
| | | me up to the nurses' station | | | | | |
| | | tween 3:00 a.m. and 5:00 | - 1 | | | | |
| | | cigarettes at those times. et another 5 cigarettes. | | | | | |
| | *He kept his own light | | | | | | |
| *On 5/4/25: | | | | | | | |
| -RN C was administering residents' medications | | | | | | | |
| | between 5:00 p.m. ar | | | | | | |
| | | ticed resident 1 was not out | | | | | |
| | overslept." | m. "She wondered if he had | | | | | |
| | She sent CNA F to o | check on him. | | | | | |
| | *CNA F went to reside | ent 1's room, had "eyes on | | | | | |
| | him", returned, and to | old her resident 1 had thrown | | | | | |
| | up. | | - 1 | | | | |
| | | ormation regarding resident t 6:00 p.m. to RN D during | | | | | |
| | the change of shifts re | | | | | | |
| | | end of shift report with RN | | | | | |
| | D at 6:20 p.m. | ,22 | | | | | |
| | | nurse I would have checked | | | | | |
| | | nad thrown up, but [I] didn't | | | | | |
| | since [CNA F] "had la *She agreed there wa | | | | | | |
| | documentation in resi | | | | | | |
| | regarding his conditio | on on 5/4/25 at 6:00 p.m. | | | | | |
| | | e usually would have charted | Ľ. | | | | |
| | | p.m. without completing | | | | | |
| | the documentation. | ork on 5/5/25 at 6:00 a.m. | | | | | |
| | | I C end of shift report. | | | | | |
| | *RN D said resident 1 | | | | | | |
| | -Not been down to ge | | | | | | |
| - | | nad thrown up blood on | | | | | |
| | 5/4/25 around 7:00 p. | | | | | | |
| | *RN D had asked res | ident 1 if he had cleaned it | | | | | |

PRINTED: 06/24/2025 FORM APPROVED South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 11048 06/09/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 337 Continued From page 15 S 337 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."
- *RND 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
- *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

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | The state of the s | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 11048 | B. WNG | | | C 09/2025 | |
| | ROVIDER OR SUPPLIER | ED LIVING 515 OHIO | DRESS, CITY, STA STREET A, SD 57073 | ATE, ZIP CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| S 337 | floor by the toilet andThe blood was drie *RN C had: -Talked to DON B reg -Not documented on a throwing up before lea of her shiftAsked DON B if she resident 1DON B had told her needed to document *She reported off to th *No education was pr disciplinary action wa regarding resident 1. Interview on 6/9/25 at administrator A regard *He had requested ac during the interview. *He had worked at the years as an RNHe always worked th *The night shift hours through 6:30 a.mThere was one nurse night shifts. *He had come to work "clocked in" at 6:00 p. wait for the end of shi *The residents were a wore Wanderguards (devices), and some w self-transferring. *RN C had reported re down for supper beca -RN C had not reported blood. | on the wall. d and bright red. arding resident 1. 5/4/25 regarding his aving the facility at the end should back chart on that in the future, she what happened. ne nurse. ovided to the nurses and no s completed for anyone 10:10 a.m. with RN D and ding resident 1 revealed: dministrator A be present e facility for almost five e night shift. were from 10:00 p.m. e and one CNA on during the c on 5/4/25. He had m. and went to the office to fit report. octive after supper, some wearable door alarming fere exit-seeking and esident 1 had not come | 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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| | Published Property and Company of the Company of th | | A. BUILDING: | | | |
| | | 11048 | B. WNG | | 06/09 | 9/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADDI | RESS, CITY, STA | TE, ZIP CODE | | |
| DADKWE | W APARTMENTS ASSIST | 515 OHIO S | TREET | | | |
| FARRVIE | W AFARTMENTS ASSIST | ED LIVING WAKONDA | , SD 57073 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| S 337 | Continued From page | : 17 | S 337 | | | |
| | *They finished up with counted narcotics, an lights" and get resider following the evening *He did not know if RI resident 1 prior to her end of her shift. *He couldn't remembe check on resident 1. Fresident 1 having vom fact." *Resident 1: -Came down to the nup.m. to 7:30 p.m. to get and the resident 1 had said not resident 1 had said not resident 1 had said not resident 1's hygiene was independent, alet *RN D had not complet assessment on reside *RN D had asked resident 1 responded -There was no obvious cognition. -He was cold but "here that shift to A E had seen resident shift to A E had seen resident 1." *He agreed the physic was to have checked to the service of the physic was to have checked to the service of the physic was to have checked to the service of the physic was to have checked to the physic was to have checked to the property of the physic was to have checked to the physic was to the physi | the end of shift report, dhe started to "mitigate call ints out of the dining room meal." N C had checked on leaving the facility at the er if RN C had asked him to the had thought the report of inted was "Just a point of eth his medications." If he could look at it, or, that he had cleaned it up. was not the greatest, he eth, and oriented. The eth oriented is entered vital signs or an ent 1. If he could look at it, or, that he had cleaned it up. was not the greatest, he eth, and oriented. The eth oriented is change in resident 1's eth threw up blood." If threw up blood." If threw up blood." If the could look at it, or, that he had cleaned it up. was not the greatest, he eth oriented. The eth oriented is change in resident 1 is eth oriented. The eth oriented is change in resident 1 is eth oriented in the remainder of eth was not uncommon for eth oriented in the remainder of eth oriented in the resident 1 is order for resident 1 or resident 1 at midnight, | | | | |
| | -There was no obvious cognitionHe was cold but "he was cold but "he was normal"Nothing unusual, juss *RN D did not see resistant shift *CNA E had seen resistance around midnight, which him. *From around 7:30 p.m. a.m. on 5/5/25 RN D mare sident 1." *He agreed the physic was to have checked 2:00 a.m. and 4:00 a.m. | s change in resident 1's was always cold." It threw up blood." ident 1 the remainder of Ident 1 go outside to smoke th was not uncommon for Im. on 5/4/25 through 6:00 had "not laid eyes on Ident 1 on resident 1 on resident 1 at midnight, | | | | |

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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X | | | (X3) DATE SURVEY COMPLETED | |
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| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | | |
| | | 11048 | B. WING | | 06/0 | 9/2025 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | | |
| 515 OHIO STREET | | | | | | | |
| PARKVIE | N APARTMENTS ASSIST | TED LIVING | , SD 57073 | | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N | (X5) | |
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| S 337 | Continued From page | e 18 | S 337 | | | | |
| | • | | | | | | |
| | have. | E had not gone to the Al | | | | | |
| | either. | E had not gone to the AL | | | | | |
| | CONTRACTOR CONTRACTOR | he change of shifts, RN C | | | | | |
| | had come on duty. | and online or or mite, the o | | | | | |
| | | nd of shift report, they | | | | | |
| | counted medications | (narcotics), he told RN C | | | | | |
| | that resident 1 had no | | | | | | |
| | 2 2 | n't always uncommon for | | | | | |
| | him. | of a first order | | | | | |
| | of an amount of the control of the c | 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 | | | 12 | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | is arms were by his side. | | | | | |
| | | l and dilated, and there was | | | | | |
| | no cardiac activity. | and the standard | | | | | |
| | bread. | peanut butter, jelly, and | | | | | |
| | | C and asked her to come to | | | | | |
| | resident 1's room with | | | | | | |
| | *They both went to re | esident 1's room. | | | | | |
| | The company of the control of the co | 1's body was cool to the | | | | | |
| | | sign of rigor mortis, and he | | | | | |
| | | blood pressure or pulse. | | | | | |
| | | e on the floor he typically | | | | | |
| | would have done vita | l signs. I on the floor, there was a | | | | | |
| | | th, there was no blood on his | | | | | |
| | face or shoulder. | , | | | | | |
| | -In the bathroom was | a wadded up washcloth in | | | | = | |
| | the shower with no vi | | | | | | |
| | -There were two pea- | sized blood spots on the | | | | | |
| | wall by the toilet. | | | 15 | | | |
| | | urses' station and called the | | | | - 1 | |
| | physician and the fan | - | | | | | |
| | -RN C went outside to | o smoke and then returned | | | | | |

| South Da | akota Department of He | ealth | | | | |
|---|--|---|---|---|-------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 3 3 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
| | | 11048 | B. WING | | 06/0 | 9/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | ST | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| | | 51 | 15 OHIO STREET | | | |
| PARKVIE | W APARTMENTS ASSIST | ED LIVING W | AKONDA, SD 57073 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| S 337 | Continued From page | 19 | S 337 | | | |
| | to the medication cart patient and a hospice *Resident 1's family w to use. *He called DON B and regarding resident 1. *Around 7:30 a.m. he asked RN C if she ne *He had called DON B her by telephone at a *He confirmed he had record by documenting checks on him, and her second to the second secon | to deal with a hospice nurse. vas not sure which mortual disocial services director of finished his calls, and the eded anything. Bright away and spoke wipproximately 8:00 a.m. displayed falsified resident 1's careing he had completed nightladn't done that. more than it should have, | ory G en ith | | | |
| | during the above interest the ongoing investigated *There was an ongoing incident. *They had a plan of cet *Moving forward, they write down times whee finished with the tasks *DON B had followed verified it had occurree *The nurses were reearounds with residents. Interview on 6/9/25 at | were educating the staff to in doing tasks and when is. up on the incident and had. ducated on completing | to | | | |
| | interviews regarding r *RN C should have co and charted an asses time it was reported to *DON B's expectation assessments and doo | resident 1 revealed: completed an assessment esment on resident 1 at the coher that he had vomited. es were for the nurses to de | e do | | | |

happened, and should have.

| South Dakota Department of Health | | | | | | |
|---|--|--|---|---|-------------------------------|------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
| | | 11048 | B. WING | | 06/0 | 9/2025 |
| NAME OF D | POVIDED OD SUDDUJED | 155.57.50 | DDRESS, CITY, STA | TE ZIP CODE | 1 00/0 | 012020 |
| NAME OF P | ROVIDER OR SUPPLIER | | O STREET | (IE, ZIF GODE | | |
| PARKVIE | N APARTMENTS ASSIST | TED LIVING | DA, SD 57073 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
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| | | | | DEFICIENCY) | | |
| S 337 | Continued From page | e 20 | S 337 | | | |
| | *RN C and D both fel | I short on assessing and | | | | |
| | following up regarding | | | | | |
| | *DON B agreed both | | | | | |
| | Should have checke Should have comple | | | | | |
| | | cumentation on his change | | | | |
| | in condition. | | | | | |
| | -RN D should not have | ve falsified resident 1's care | | | | |
| | | pleting nightly checks. | | | | |
| | *DON B had: | 1 | | | | |
| | *Completed an intern *Provided the investig | | | | | |
| | resources). | gation to HK (numan | | × | | |
| | | D, met with him the following | | | | |
| | week, provided discip | | | | | |
| | reeducation on how t | | | | | |
| | | ns were for the staff to | | | | |
| | complete the rounds | | | | | |
| | | eted an incident report. ed the incident to the SD | | | | |
| | DOH. "In hindsight, w | | | | | |
| | | expected RN D after having | | | | |
| | | ne floor to have checked his | | | | |
| | The second secon | Itated for his pulse when | | | | |
| | verifying the resident | 's condition (death). | | | | |
| | Observation on 6/9/2 | 5 at 11:10 a.m. of resident | | | | |
| | | nt with DON B revealed no | | | | |
| | areas of blood. | | | | | |
| | Daview of the previde | ada raviand May 2010 | | | | |
| | Reporting Requireme | er's revised May 2019 | | | | |
| | *Purpose: | and policy revealed. | | | | |
| | | epartment of Health (DOH) | | | | |
| | pertinent information | regarding reportable events | | | | |
| | as defined by 44:70:0 | 01:07." | | | | |
| | *Policy" | a martifical cultification to become af | | | | |
| | | e notified within 48 hours of resulting from other than by | | | | |
| | | ating on the facility property | | | | |

PRINTED: 06/24/2025 **FORM APPROVED** South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C B. WING 11048 06/09/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 337 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 *"****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

-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,

physical assessment.

nurses will back time accordingly."

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PRINTED: 06/24/2025 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 11048 06/09/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 337 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 -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."

revealed:

Review of the provider's May 2013 Director of Nursing Home Administrator job description

| | ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION | | CONSTRUCTION | (X3) DATE SURVEY | | | |
|--------------------------|---|---|-----------------------|--|---------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLE | COMPLETED | |
| | | 11048 | B. WING | | C | 9/2025 | |
| | | | | | 1 06/03 | 312025 | |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| PARKVIE | W APARTMENTS ASSIST | TED LIVING 515 OHIO S | STREET A, SD 57073 | | | | |
| WALE | CLIMMARY CT | ATEMENT OF DEFICIENCIES | <u> </u> | PROVIDER'S PLAN OF CORRECTION | N. | (95) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | COMPLETE DATE | |
| S 337 | Continued From page | 23 | S 337 | | | | |
| | *"Responsible to plan aspects of [name of fathe philosophy of the consistent with State standardsCoordinates the active providing care that me and social needs of the community." Review of the provide Nursing Service job de *Job Summary: -"A. The Director of Nathe to the Administrator a standard of care withing guidelines to resident delegating, implement | n, organize and direct all acility] in accordance with [name of organization] and and Joint Commission wities of all departments in eets the spiritual, emotional, nose served by the er's undated Director of description revealed: lursing is directly responsible and shall provide a high | | | | | |
| | Review of the provide Nurse job description *V. Work Performed: -"B. Makes nursing as health status of [the] r knowledgeable of the times and reports per resident's] family, phy NursingC. Makes nursing diabasis for strategy of c-D. Develops plan of cand nursing diagnosis -E. Implements the nuassigning the nursing other nursing personn resident's needs and competence of nursing | ssessments regarding the resident and is resident's condition at all tinent changes to [the resident and [the] Director of agnosis which serves as the eare. care based on assessment as. cursing care of each resident care of each resident to nel in accordance with the the preparation and | | | | | |

FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ C B. WNG 11048 06/09/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **515 OHIO STREET** PARKVIEW APARTMENTS ASSISTED LIVING WAKONDA, SD 57073 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 337 Continued From page 24 S 337 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."