STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49736	A. BUILDING: _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SPEARFISH SENIOR LIVING LLC	540 FALCON CREST DRIVE SPEARFISH, SD 57783

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S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 3/4/24 through 3/7/24. Edgewood Spearfish Senior Living LLC was found not in compliance with the following requirements: S085, S105, S130, S169, S201, S215, S325, S337, S389, S632, S680, S681, S685, S701, and S1039. 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 3/4/24 through 3/7/24. Areas surveyed included resident neglect and nursing services. Edgewood Spearfish Senior Living LLC was found not in compliance with the following requirements: S325, S389, S680, and S681.	S 000	Type text here	
S 085	44:07:02:03 Cleaning Methods And Facilities The facility shall have supplies, equipment, work areas, and complete written procedures for cleaning, sanitizing, or disinfecting all work areas, equipment, utensils, and medical devices used for residents' care. Common-use equipment shall be disinfected after each use. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to ensure there were written procedures for maintaining two of two oxygen concentrators for two of two sampled residents (11 and 12) who required the use of supplemental oxygen. Findings include:	S 085	CSC will identify all residents with O2 equipment and equipment routine maintenance dates. CSC will contact each vendor for appropriate instructions on O2 filter checks and changes and add these instructions to a monthly checklist. CSC will track all order dates and service dates of oxygen equipment on site. and report in QA committee on a monthly basis x 12 months. Providers will be notified if annual routine oxygen maintenance has not been provided by provider. Resident 11 and resident 12 will have their oxygen equipment routine maintenance completed by 4/21/24.	4-21-24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 085	Continued From page 1 1. Observation on 3/5/24 at 9:30 a.m. in resident 11 and 12's shared room revealed: *Each resident had their own oxygen concentrator and each concentrator was supplied by a different durable medical equipment (DME) provider. *DME provider maintenance information on the side of resident 11's concentrator indicated it was last serviced on 9/29/22 at which time a new filter was placed. *DME provider maintenance information on the side of resident 12's concentrator indicated it was last checked on 2/1/23 and was due to have been checked again on 2/1/24. -The oxygen concentrator filter was gray-colored with what appeared to have been dust. Interview on 3/6/24 at 12:30 p.m. with certified medication aide N regarding oxygen equipment maintenance revealed: *Oxygen tubing was replaced every three months. *She was unsure who was responsible for ensuring the routine maintenance of those concentrators. Interview on 3/7/24 at 10:45 a.m. with clinical services director (CSD) B regarding oxygen equipment maintenance revealed: *The respective DME oxygen provider was responsible for the routine maintenance of the oxygen equipment. -That should have occurred at least annually or more frequently if indicated. *Oxygen filters were expected to have been replaced during those routine maintenance visits. -Staff were allowed to clean filters with soap and water if they were visibly dusty or dirty. *She thought scheduler D tracked oxygen equipment and oxygen equipment maintenance.	S 085		

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S 085	Continued From page 2 Interview on 3/7/24 at 11:00 a.m. with scheduler D revealed she: *Kept a spreadsheet with the DME providers' contact information for those residents who required supplemental oxygen. -Contacted those providers to supply oxygen tubing to replace the existing tubing every three months and tracked that information on the spreadsheet. *Caregivers used to clean oxygen filters on a monthly basis until one of the DME providers suggested that practice might compromise the integrity of the filter. *The dates of oxygen filter replacement and routine maintenance checks for each resident requiring supplemental oxygen were not tracked and it was not known if either was occurring. An Oxygen Equipment Maintenance policy was requested from executive director A on 3/6/24 at 1:00 p.m. A revised March 2013 Oxygen Competency was provided.	S 085		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and review of	S 105	Area directly above the metal back-splash extending up to the middle of the wall behind and to the left of the dish machine will be appropriately cleaned and task has been added to the daily schedule. The silver metal grill on the ice machine will be appropriately cleaned to remove rust colored stains and lime build-up and a task will be added to the daily cleaning schedule. This will be monitored by the DSD on a weekly basis x 2 months, E/O week x 4 months and monthly thereafter for 6 months. This will be communicated to the QA committee on a monthly basis by DSD. Staff was educated on both cleaning issues identified with signed documentation.	4/21/24

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S 105	Continued From page 3 the daily kitchen cleaning schedule, the provider failed to ensure the following: *Proper cleaning of one of one wall behind and alongside the dish machine. *Proper cleaning and de-liming of one of one ice machine to prevent limescale buildup. Findings include: 1. Observation on 3/4/24 at 10:30 a.m. during the initial tour of the kitchen revealed: *Directly above the metal backsplash extending up to the middle of the wall behind and to the left of the dish machine was a black substance caused by an unknown source. -The black colored substance was most concentrated on the wall behind the dish machine, on and below the wall-mounted holder for the Ecolab Silver Power cleaner, and around and below the wall-mounted Salvajor food waste disposer box. *On the ice machine: -The silver metal grill that sat on top of the drain tray had rust-colored stains and white-colored lime build-up on it. -Below the grill and inside of the plastic drain tray there were patches of dried rust-colored material at each end of the tray. -White-colored lime build-up surrounded the perimeter rim of and beneath the drip tray. Interview on 3/4/24 at 11:20 a.m. with cook Q in the kitchen revealed: *A daily cleaning schedule was posted in the kitchen and included the following: -Individual lists of cleaning tasks to have been initialed daily upon completion by the day cook, supper cook, prep cook, morning dining assistants, and evening dining assistants. *The morning and evening dining assistants were each expected to "wipe walls in dish area".	S 105		

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S 105	Continued From page 4 *There was no task-specific cleaning of the ice machine. -The day and evening cooks were assigned undefined "extra cleaning". Observation and interview on 3/6/24 at 9:30 a.m. with cook K revealed: *The wall and ice machine remained in the same condition as they had been observed during the initial kitchen tour on 3/4/24 at 10:30 a.m. *She stated the black marks on the wall were caused by metal sheet pans rubbing against the wall and/or grease build-up from the dish machine. *She confirmed the build-up on and around the ice machine drip tray. Interview on 3/6/24 at 10:30 a.m. with dietary manager F regarding the observations referred to above revealed: *Those black areas on the wall by the dish machine were removed earlier that morning. -The daily cleaning expectation per the cleaning schedule had not occurred on 3/4/24 or on 3/5/24. *The ice machine had "a drip for awhile" which may have caused the staining and lime build-up on the silver metal grill. -Routine cleaning and maintenance of that grill was not performed.	S 105		
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012.	S 130		

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S 130	Continued From page 5 The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the infection prevention and control practices were implemented for the following: *Proper hand hygiene and glove use by one of one personal care attendant (PCA) (J) during personal care for one of one sampled resident (7). *Proper hand hygiene and glove use by one of one certified medication aide (CMA) (H) during a skin treatment for one of one sampled resident (3). Findings include: 1. Observation and interview on 3/4/24 between 10:50 a.m. and 11:00 a.m. with PCA J who assisted resident 7 with toileting in the bathroom next to the beauty shop revealed: *After performing hand hygiene and putting on a clean pair of gloves PCA J removed resident 7's soiled pull-up brief and discarded it in the garbage can. *Without removing her gloves, performing hand hygiene, and putting on a new pair of gloves she then: -Placed the resident's feet through the leg openings of a clean pull-up brief. -Used incontinence wipes to clean the resident's peri-area and buttocks. -Pulled up the clean pull-brief then pulled up the resident's pants. *PCA J removed and discarded those same	S 130	PCA J and CMA H will be properly trained with a signed acknowledgement and competency completion of "Proper hand Hygiene" and glove usage. A training will be assigned and completed by all staff on a yearly basis and cover "Proper Hand Hygiene and Glove Usage". CSD will perform Proper Hand Hygiene audit on 4 individuals per month for 3 months, and 2 individuals per month for 3 months and monthly there after for 6 months. This will be reported to the monthly QA committee by the CSD.	4/21/24

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S 130	Continued From page 6 gloves and without performing hand hygiene she then: -Turned on the water faucet at the sink for the resident to wash her hands. -Provided no instruction for the resident to use soap while washing her hands. -Handed the resident a paper towel to dry her hands then discarded the wet towel for the resident. -Used her unclean hand to hold the resident's unclean hand and walked her back to the beauty salon. *PCA J agreed that she: -Missed glove changes and hand hygiene opportunities before,during, and following resident 7's care. -Failed to instruct and/or physically assist the resident to perform proper hand hygiene that included using soap before leaving the bathroom. 2. Observation and interview on 3/4/24 at 3:50 p.m. with CMA H completing a skin treatment for resident 3 in her room revealed: *She performed hand hygiene, put on a clean pair of gloves then: -Placed the prescription ointment on a 2 inch by 3 inch Telfa pad and placed it on a clean barrier. -Removed the old Telfa pad from the resident's back. --There were two small spots of light-tinged blood on that old Telfa pad. *Without removing her gloves, performing hand hygiene, and putting on a new pair of gloves she: -Placed the newly prepared Telfa pad on the resident's back and secured it with tape. *She was unsure if she should have changed her gloves after removing the old Telfa pad and before applying the new Telfa pad. -The above observation was her usual process	S 130		

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S 130	Continued From page 7 for performing the resident's skin treatment. 3. Interview on 3/6/24 at 3:00 p.m. with clinical services director B regarding the observations referred to above revealed: *She was responsible for the facility's infection prevention and control program and the nursing services director. *PCA J and CMA H had not used appropriate glove use or performed hand hygiene between care transitions for residents 7 and 3. -Those failures increased the resident's risk for infection. Review of the revised February 2023 Hand Hygiene policy revealed hand hygiene was performed before putting on and after removing gloves. Review of the undated Gloves, Gowns, and Masks, policy revealed: *Hand hygiene was performed before applying gloves. *Gloves were removed after handling "contaminated materials" and hand hygiene was performed after glove removal.	S 130		
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed;	S 169	Cognitively impaired residents do not reside in our assisted living area therefore North exterior door entering the courtyard does not need to be locked, alarmed or attended. Current license documenting Cognitively impaired residents is all inclusive on current license.	N/A

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S 169	Continued From page 8 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain exterior doors in a locked or alarmed condition at one random location (courtyard door adjacent to the medical supplies room 130). Findings include: 1. Observation on 3/5/24 at 10:20 a.m. revealed an exterior door to the courtyard adjacent to the medical supplies room 130. The door was not a marked exit, was not locked to prevent egress by cognitively impaired residents, and was not equipped with an alarm to alert staff if a resident left the building. Interview with the maintenance supervisor at the time of the above observation confirmed that finding.	S 169		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (closing corridor doors and checking the door for the fire	S 201	Environmental Director will ensure all staff are familiar with our fire drill procedures by personal instruction and demonstration at the next quarterly staff meeting. The Maintenance director will then conduct monthly fire drills every month. This will be reported to the Quality Assurance Committee on a monthly basis by the Maint. Director. Corridor door for the employee break-room did have an installed wall mounted door wedge installed prior to end of survey period. The electrical cord on the back side of the plate warming unit was replaced prior to end of the survey period.	4/21/24

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S 201	Continued From page 9 location). Findings include: 1. Observation on 3/5/24 at 1:55 p.m. revealed a fire drill was initiated by activating a corridor smoke detector close to resident room 126. Interview with the maintenance supervisor at the above time revealed the provider was using a defend-in-place method of response to the fire alarm rather than evacuation. The simulated fire sign was placed in room 126 with the resident in the room at that time. Staff responded to the fire alarm in the corridor with several fire extinguishers and closed most of the doors but did not check or close the corridor door for resident room 126. Staff then silenced the alarm and declared "all clear" while room 126 had not been checked or cleared. Further observation at the simulated fire location with staff revealed inconsistent understanding of alarm announcement (3 times needed), resident rescue, and checking and entering potential fire locations behind closed doors. Interview with the maintenance supervisor at the time of the above observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the building. B. Based on observation and interview, the provider failed to maintain clear space at the sidewall sprinkler in the medical supplies room (adjacent to room 130). Findings include: 1. Observation on 3/5/24 at 10:25 a.m. revealed a free-standing plastic shelving unit directly beneath the sidewall sprinkler in the medical supplies room (adjacent to room 130). The top shelf of the	S 201	Clear space will be maintained at the sidewall sprinkler in the med supply room. A sign has been placed in this area indicating the correct and proper clear space as to not create an obstruction.	4-21-24

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S 201	Continued From page 10 unit was approximately 10 inches below the sprinkler. The top shelf had a box, plastic container, and cloth stored on it. Those items created obstructions of the sprinkler discharge pattern. Interview with the maintenance supervisor at the time of the above observation confirmed that finding. C. Based on observation and interview, the provider failed to maintain smoke-free corridors by allowing doors to be wedged open (employee breakroom). Findings include: 1. Observation on 3/5/24 at 10:40 a.m. revealed the corridor door for the employee breakroom was held open with a wood floor wedge. Interview with the maintenance supervisor at the time of the above observation confirmed that finding. D. Based on observation, interview, and review of the National Fire Protection Association (NFPA) 70 standards, the provider failed to ensure an electrical cord for one of one plate-warming unit was in safe working order. Findings include: 1. Observation on 3/4/24 at 11:20 a.m. in the kitchen revealed: *There was a plate-warming unit plugged into an outlet next to the food serving counter. -Kitchen staff removed individual warmed plates from the unit then dished food onto that warmed plate. *The electrical cord for the plate-warming unit was wrapped with black electrical tape several inches in length where it connected to the backside of the warming unit.	S 201	An audit of this area will be done weekly x 2 months, every other week x 2 months and monthly x 2 months to ensure no obstruction is identified. This will be communicated by the Maintenance Director to the QA committee on a monthly basis.	

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S 201	Continued From page 11 Observation and interview on 3/6/24 at 9:30 a.m. with cook K regarding the plate-warming unit revealed: *The wiring inside the electrical cord was exposed when the electrical tape was pulled back. *Cook K was unaware that part of the electrical cord was wrapped in electrical tape. Observation and interview on 3/6/24 at 10:30 a.m. with dietary manager F regarding the plate-warming unit revealed she was not aware of the condition of the electrical cord or how long it had been that way. Interview on 3/6/24 at 11:00 a.m. with maintenance supervisor G regarding the plate-warming unit revealed: *He was not aware of the condition of the electrical cord. -The plate-warming unit should have been removed from service when the frayed electrical cord was first noticed. Review of the NFPA 70 standards revealed: *A frayed cord may not have tripped a breaker and could have potentially started a fire. *Damage to insulation that provided protection against shocks or electrocution was another potential danger caused by frayed electrical cords.	S 201		
S 215	44:70:03:03 Fire Extinguisher Equipment Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C;	S 215		

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S 215	Continued From page 12 (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to conspicuously note inspection dates for the tags for two randomly observed fire extinguishers (labeled at the #3 and the #13 locations) for February 2024. Findings include: 1. Observations beginning on 3/5/24 at 8:55 a.m. revealed two fire extinguishers (#3 and #13) in the 100 wing corridor that had not been signed for inspections for the month of February 2024. Interview with the maintenance supervisor at the time of the observations confirmed those findings. The deficiency affected one of numerous requirements for installing and maintaining fire extinguishers.	S 215	Environmental Director will audit all fire extinguishers on a monthly basis to ensure inspection and notation are present and report this to the QA committee monthly. Fire extinguisher #3 and #13 will be inspected immediately.	4/21/24
S 325	44:70:04:09 Disease Prevention Each facility shall provide an organized infection control program for preventing, investigating, and	S 325		

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S 325	Continued From page 13 controlling infection. The facility shall establish written policies regarding visitation in the various services and departments of the facility. Any visitor who has an infectious disease, who has recently recovered from such a disease, or who has recently had contact with such a disease shall be discouraged from entering the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, review of the 1/1/24 Reportable Diseases-South Dakota reference list, and policy review, the provider failed to document communicable disease monitoring and tracking, and report to the South Dakota Department of Health (SD DOH) for two of two disease outbreaks. Findings include: 1. Interview on 3/7/24 at 9:45 a.m. with clinical services director (CSD) B revealed: *During October 2023 there were residents who experienced symptoms consistent with a "stomach bug". -Diarrhea and nausea with some vomiting were the most common complaints. *"About 25% of the [resident] population" was affected. -Most of those residents resided in the memory care unit (MCU) and a few of those residents were in the assisted living (AL) area of the facility. *The facility's in-house medical provider was notified of the illnesses and issued standing orders for those affected including: Zofran (anti-nausea), loperamide (anti-diarrhea) and increased fluid intake. -Norovirus was the presumed diagnosis made by the in-house medical provider but that was not test-confirmed. *During November 2023 there were staff and residents who tested positive for coronavirus	S 325	Any reportable disease listed on the DOH reportable disease reference will be reported to the SD DOH by a Registered Nurse or Licensed Prac. Nurse on a monthly basis, the Clinical Services Director will review 50% or a minimum of 5 confirmed reportable cases for the previous month within the community to confirm appropriate reporting. This will be reviewed in the QA committee on a monthly basis by the CSD. This will be monitored monthly x 6 months and every other month thereafter for 6 months by the Clinical Service Director. It should be noted that on 10-30-23 a SD Confidential disease report was submitted to the state for illneses that occured on 10-9-23 thru 10-23-23. Type text here Type text here	4/21/24

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S 325	Continued From page 14 (COVID-19). -Upper respiratory and some gastrointestinal issues were the most common symptoms of that illness. -About 10 residents who resided on the Pink and Brown halls in the AL area of the facility and "some" staff tested positive for COVID-19. Continued interview with CSD B regarding management of the disease outbreaks referred to above revealed she: *Was responsible for the implementation of the facility's infection prevention and control program. *Provided staff education including hand hygiene and the use of personal protective equipment (PPE) in response to the two outbreaks referred to above. *Failed to document monitoring of the outbreaks to identify the spread of the diseases. *Failed to track the progression of those diseases to have known how to best manage the spreading of those diseases. *Knew about the 1/1/24 Reportable Diseases-South Dakota resource that listed the names of diseases expected to have been reported to the SD-DOH but had not reported them. -That list included COVID-19 respiratory syndromes and outbreaks of diarrheal disease. A Communicable Disease Management policy was requested of CSD B on 3/7/24 at 9:45 a.m. A revised November 2023 COVID Triage and Management policy and a selection of unnumbered pages from the facility's Exposure Control Manual were provided. The revised November 2023 COVID Triage and Management policy revealed: *"All actual or suspected communicable disease	S 325		

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S 325	Continued From page 15 situations for residents and employees should be reported to the Regional Nursing Director, Regional Vice President, and Incident Command." *"The CSD (or executive director where applicable) will delegate the following monitoring expectations:" -Testing -Routinely documented nurse assessments, per licensed nurse direction. -Resident vital signs, per licensed nurse direction. -Individualized clinical interventions to ensure appropriate fluid intake, nutritional needs, symptom management, and hygiene assistance. *PPE use was expected during an outbreak. *Environmental infection control measures were expected to be routinely implemented. *There was no documentation in the policy regarding disease monitoring, tracking, or SD DOH notification when a communicable disease outbreak occurred.	S 325	Type text here	
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 observation, interview, and policy review, the provider failed to ensure: *One of one certified medication aide (CMA) (I) who primed an insulin pen and dialed the insulin dose for one of one sampled resident's (4) insulin administration had received unlicensed diabetic aide (UDA) training by a registered nurse (RN)	S 337	Staff member I and staff member M and CSD Bwill be educated on the proper UDA training prior to performing tasks related to insulin pen injection. Education, training, and competencies will be completed by all staff who will be administering insulin. Resident #4 will be advised that all insulin related tasks need to be performed independently. CSD will monitor insulin related tasks by 4 x per month for 2 months, 2 x per month for 2 months and 1x per month x 6 months to ensure all insulin related tasks are being completed independently by resident or UDA at all times. This will be monitored monthly and brought to the QA committee.	4/21/24

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S 337	Continued From page 16 before performing those tasks according to South Dakota Board of Nursing (SD BON) rules. *One of one CMA (M) who dialed the insulin dose for one of one sampled resident's (4) insulin administration had received UDA training by an RN prior to performing those tasks according to SD BON rules. Findings include: 1. Observation and interview on 3/4/24 at 4:30 p.m. with CMA I in resident 4's room revealed: *CMA I: -Placed the needle on the insulin pen device then turned the dial of the pen to "2" units and primed the pen. -Turned the dial of the pen to "4" units. *Resident 4: -Wiped her abdomen with an alcohol pad. -Inserted the insulin pen needle into her abdomen, pushed the dose button, and administered the insulin. -Held the needle in her skin until the full dose was administered. *That was CMA I's first day working alone on the medication cart. -She was a new CMA and just completed her on-the-job training with a CMA educator. *CMA I was not a UDA. 2. Observation and interview on 3/5/24 at 10:54 a.m. with CMA M in resident 4's room revealed: *CMA M: -Placed the needle on the insulin pen device then turned the dial of the pen to "4" units. *Resident 4: -Inserted the insulin pen needle into her abdomen, pushed the dose button, and administered the insulin. -Held the needle in her skin until the full dose was administered. *CMA M was not educated to prime the pen	S 337		

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S 337	Continued From page 17 before dialing up the dose of insulin. *CMA M was not an UDA. 3. Interview on 3/5/24 at 1:52 p.m. with clinical services director (CSD) B regarding the above observations revealed she: *Was not aware the SD BON rules had considered priming a resident's insulin pen and dialing an insulin dose a part of the insulin administration process. -Agreed those tasks were not appropriate to delegate to a CMA who had not completed the UDA training. Review of the December 2023 Medication Administration policy revealed "M. A Registered Nurse will determine competency of staff authorized to administer medications where applicable." Review of the December 2023 Insulin Pen policy revealed: "All medication aides [UMAs] will have Insulin Administration by Pen Competency completed by a Registered Nurse."	S 337	Type text here	
S 389	44:70:04:18(1-3) Admission/Retention... Communicable Diseases If the facility admits a resident with any of these diseases or antibiotic resistant organisms, or if after admission, a resident is suspected of having a communicable disease or antibiotic resistant organism, the following conditions must be met: (1) All healthcare personnel shall have received education related to infection control measures and information about the state's reportable diseases list; (2) The facility shall have written procedures and	S 389		

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S 389	Continued From page 18 protocols for healthcare personnel to follow to avoid exposure to the resident's blood or body fluids; and (3) The facility shall have a written infection control policy and procedures in practice that prevent the spread of a communicable disease. This Administrative Rule of South Dakota is not met as evidenced by: Based on interviews, record reviews, and annual training calendar review, the provider failed to ensure all current employees had the required Incident and Disease mandatory reporting training. Findings included: 1. Interview and record reviews on 3/6/24 at 9:30 a.m. with business office manager P regarding annual training for employees revealed: *The Incidents and Diseases subject to mandatory reporting and the facility's reporting mechanism was not completed by any of the employees for their annual training. -They had covered the topic within 30-days of hire for new employees only. *She was unsure why the topic was not covered annually. *She was not in charge of the training. -The trainings were completed in the Relias online training course module but she was unsure if that topic was covered. 2. Review of the provider's annual training calendar revealed: *Under the topic, "Requirements not covered on annual training calendar" listed: -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism.	S 389	All employees will have the required Incident and Disease Mandatory reporting training on a yearly basis. An Annual training course has been added to yearly relias program and will be tracked digitally for compliance by BODirector. BODirector will monitor and report this yearly through QA committee that this is completed	4-21-24

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S 389	Continued From page 19 -Relias module: N/A. Refer to S325	S 389		
S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and skills assessment review, the provider failed to ensure the accuracy of one of one sampled residents (4) Novolog insulin medication label with the current physician's order for that insulin. Findings include: 1. Observation and interview on 3/4/24 at 4:30 p.m. with certified medication aide (CMA) I after she removed resident 4's Novolog insulin pen from her locked medication drawer for the resident to self-administer revealed: *Her Medication Administration Record (MAR)	S 632	Provider will provide accuracy of medication labels by ensuring any medication order change has a MAR change sticker applied to the medication card/label by our clinical services dept. CSD will do an audit of 8 medications that have been changed, on a monthly basis x 3 months and audit 4 medications that have been changed x 3 months and 1 medication that has been changed thereafter to ensure accuracy. Resident 4 novolog insulin pen label has since been replaced with correct resident name, physician, medication name, strength and prescription dose. Will review P&P with CMA N and CMA I to ensure understanding with a signed acknowledgement. Will incorporate yearly training with all staff who pass meds.	4/21/24

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S 632	Continued From page 20 order for Novolog read: Administer 4 units of Novolog twice daily with the noon and evening meals. *The pharmacy label on the Novolog insulin pen had three separate doses and administration times for each dose: -"4" units at breakfast. --The 4 was written in black marker over the top of a previous dose. -"10" units at lunch. -"10" units at supper. *CMA I knew the label instructions for the Novolog were wrong and she referred to the MAR for the correct dose of insulin the resident was to have administered. Interview on 3/6/24 at 12:30 p.m. with CMA N revealed she contacted a nurse for direction when the resident's medication label instructions had not matched the MAR instructions for the same medication. Interview on 3/7/24 at 10:00 a.m. with clinical services director (CSD) B regarding medication labeling revealed: *The nurse who entered the practitioner's medication order change was responsible for placing a "MAR Change" sticker on the applicable medication label. *CMA I should have notified the nurse when the pharmacy label instructions for resident 4's Novolog had not matched the practitioner's Novolog order on resident 4's MAR. *CSD B had hand-written the number "4" on the Novolog label. -Agreed only a licensed pharmacist should have altered a prescription label. Review of the undated Insulin Pen Verification skills assessment revealed:	S 632		

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S 632	Continued From page 21 *Insulin Pen/Syringe Verification Skill: -4. Check medication label and MAR for the right resident, right medication, right dose, right route and right time. -6. Check medication label a second time for allergies, drug expiration, and specific instructions. -7. Perform a third safety check including checking the label with the MAR to be sure correct insulin and amount have been set-up.	S 632	Community will ensure staff are not falsely documenting or presetting resident medications by performing a sample of audits while medication administration is being performed.	
S 680	44:70:07:08 Medication Records And Administration A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication. This Administrative Rule of South Dakota is not met as evidenced by: Based on complaint review, interview, record review, and policy review, the provider failed to ensure: *One of one certified medication aide (CMA) (R) had not: -Falsely documented medication administration that she had not performed. -Pre-set 7:30 p.m. and 9:30 p.m. resident medications together to have been administered during one medication pass. *The facility's process for medication error reporting, investigation, and follow-up was	S 680	Will review Medication Administration P&P with CMA R and CMA L with signed acknowledgement. Will incorporate into our yearly training program a review of our Medication administration P&P with all staff who pass medications. Education on the med error P&P will be reviewed with all LPN/RN's with signed acknowledgement. Medication errors will be reviewed on a monthly basis by an LPN or RN to ensure P&P is being followed by all staff passing medications. The CSD will review 50% or no less than 5 monthly documented med errors and ensure point system has been applied. This will be monitored in our monthly QA committee for 6 months. 25% or no less than 5 documented med errors will then be reviewed monthly for 6 months to ensure compliance with P&P. Audits on 4 med aides will be done on a monthly basis to ensure visually P&P is being followed. This will be completed by CSC, reported on a monthly basis to the QA committee.	4/21/24

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S 680	Continued From page 22 implemented for seven of seven medication error reports involving one of one sampled resident (4). Findings include: 1. Review of a report received on 3/5/24 by the South Dakota Department of Health Complaint Department there was a complaint about resident medications being documented incorrectly and medications being pre-set and combined for two different medication passes. 2. Interview on 3/5/24 at 2:42 p.m. with CMA L revealed: *She had been employed with the facility since 9/25/23. *She had just completed her CMA training a couple weeks ago. -She was trained by two different CMA's. *On 2/9/24 she was trained by CMA R. -She had come back from her break, and was told by two unidentified staff members that CMA R was pre-setting medications. -She had asked CMA R if that was correct and was told by CMA R it was easier and goes smoother to pre-set the resident's medications. -She had noticed when the top drawer of the medication cart was open there were medication cups in a line with multiple pills in them. -The pre-set medications included two different medication passes. --CMA R informed her that she was not feeling well and wanted to go home early. -CMA R documented that she had administered all the 7:30 p.m. medicaitons in the computer under CMA L. -Before CMA R went home early, she documented the 9:30 p.m. p.m resident's medication administration in the computer that was given at the early time, under CMA L. *CMA L went to the assistant clinical services	S 680		

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S 680	Continued From page 23 director (ACSD) C. -She was informed that she was possibly getting the medication error as it was documented under her name in the computer. *At that time, she had not been informed of any training's or disciplinary action that had taken place. Interview on 3/5/24 at 2:52 p.m. with ACSD C regarding the above interview revealed she: *Was notified by the lead CMA of the possibility of pre-setting of residents medications by CMA R. -Could not recall the whole conversation she had with the lead CMA. *Remembered educating both the CMAs regarding the pre-setting of the resident's medication and correct documentation. *Interviewed CMA R and she denied pre-setting or documenting under CMA L. -Had no documentation to verify she educated or interviewed either of the CMA's. -Had completed random audits to see if CMA R was pre-setting, but had not documentation of those audits. Interview on 3/7/24 at 8:15 a.m. with executive director (ED) A, clinical services director (CSD) B, and ACSD C revealed: *They agreed that CMA R had documented under CMA L on 2/29/24, and that was not allowed. *They had not completed a medication error report for that night as it was hear-say, and CMA R denies pre-setting the residents medications. -They were doing verbal audits as they had been notified about CMA R possibly pre-setting medications before. -They had no documentation of any training or discussion that pre-setting and documentation under another staff member was not allowed. *CMA R had not trained any CMAs since then.	S 680		

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S 680	Continued From page 24 *Management and the lead CMA had begun completing documented audits on the day and night shifts. Review of the revised March 2023 Medication Errors and Reporting policy revealed: *Medication Errors May Include: -Wrong time: "Administration of a dose outside of the prescribed time (60 minutes before or after the scheduled time)." -Documentation: "Failure to document the medication at the time of the administration." 3. Review and interview on 3/6/24 at 3:00 p.m. with ACSD C regarding resident 4's electronic care record revealed: *The resident had seven medication error incident reports during November 2023. *The 11/14/23 medication error incident report revealed the resident failed to receive a scheduled blood pressure medication because it was "DC'd" [discontinued] however the medication was not discontinued and should have been administered as ordered. *The medication error was reported to her. -It was her responsibility to investigate that medication error and document her findings on that incident report. *ACSD C was responsible for but had not completed a thorough investigation of the medication error. Interview on 3/6/24 at 3:35 p.m. with CSD B regarding the medication error referred to above revealed: *Nursing staff were electronically notified when a medication error incident report was initiated. -It was the responsibility of the nurse to document on that same incident report the investigation of the incident. -The nature of the medication error dictated how	S 680		

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	49736	A. BUILDING: _____ B. WING _____	C 03/07/2024

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S 680	Continued From page 25 quickly the nurse was expected to process an incident report however all incident reports were expected to have been completed promptly. *Medication errors were linked to a point system. -Accrual of medication error points were grounds for disciplinary action and possible termination depending on the severity of the error and the effect of the error on the resident. *There was no accountability with the current medication error process. -That was a "gross error on my part." Review and interview on 3/7/24 at 9:30 a.m. with licensed practical nurse (LPN) E regarding resident 4's 11/15, 11/16, 11/17, 11/18, and 11/19/23 medication error incident reports revealed: *The resident received an incorrect medication dose for the same medication in all five incidents. -Two of the five incident reports had not indicated the name of the medication that was administered incorrectly. -Three different CMAs had administered the wrong medication dose. *LPN E was notified of the medication errors on 11/22/23. -She had not completed a documented investigation of those medication errors. -She was responsible for completing those medication error reports investigations. Continued review of resident 4's 11/28/23 medication error incident report with LPN E revealed: *The resident's morning gabapentin (used to treat nerve pain) dose was not administered because the CMA "forgot" to give it. *LPN E was notified of the medication error on 11/28/23 but had not completed an investigation.	S 680		

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S 680	Continued From page 26 Interview on 3/7/24 at 10:15 a.m. with ED A, CSD B, and ACSD C regarding resident 4's medication errors referred to above revealed they confirmed: *There was no documentation to support the medication error investigations were completed and documented. *There was no documentation the CMAs responsible for those medication errors received any type of education or re-training related to those medication errors. -No applicable "points" were assigned to those CMAs responsible for those medication errors. *The facility failed to follow their process for medication error reporting. Review of the revised March 2023 Medication Errors and Reporting policy revealed: *Documenting Medication Errors: -Report to licensed nurse. -"It is crucial to complete all required documentation as soon as you become aware of a medication error. Remember, it is up to everyone to help prevent medical errors and keep our residents healthy." *Medication Error Tips: -"Always provide some form of re-education to staff after a medication error occurs-these are learning opportunities. -Coach for success when necessary. -There is information on SharePoint related to the 'Point System', it is recommended that communities use this as it provided a level of consistency across the company for coaching purposes."	S 680		
S 681	44:70:07:08 Medication Records And Administration Medication errors and drug reactions must be	S 681		

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S 681	Continued From page 27 reported to the resident's physician, physician assistant, or nurse practitioner and an entry made in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure seven of seven medication errors involving one of one sampled resident (4) were reported to the practitioner. Findings include: 1. Review and interview on 3/6/24 at 3:00 p.m. with assistant clinical services director (ACSD) C regarding resident 4's electronic care record revealed: *An 11/14/23 medication error incident report revealed the resident failed to receive a scheduled blood pressure medication because it was "DC'd" [discontinued] however the medication was not discontinued and should have been given. *The medication error was reported to ACSD C. -She was responsible for but had not completed a documented investigation of this medication error that included notifying the resident's medical provider of that error. 2. Review and interview on 3/7/24 at 9:30 a.m. with licensed practical nurse (LPN) E regarding resident 4's Medication Error Incident reports revealed: *Five medication error incident reports occurred during November 2023 when the resident received an incorrect medication dose. *A sixth incident occurred in November 2023 that involved a medication dose that was not administered because the CMA "forgot" to give it.	S 681	Medication errors will be accurately reported to resident practitioner according to P&P. CSD will monitor monthly 5 med errors to confirm resident practitioner was notified. This will be done x 4 months, will then monitor 4 med errors for 4 months and follow-up with 3 med errors x 4 months. This will be reported to the monthly QA committee by the Clinical Services Director.	

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S 681	Continued From page 28 *All six of the medication error incident reports referred to above were reported to LPN E. -She was responsible for completing and documenting the investigations of those medication errors that included notifying the resident's medical practitioner of those medication errors. Interview on 3/6/24 at 3:35 p.m. with CSD B regarding the medication errors referred to above revealed: *Nursing staff were electronically notified when a medication error incident report was completed by a CMA. -It was the nurse's responsibility to document on the incident report a completed investigation of that incident which included practitioner. -There was no documentation indicating the practitioner was not notified. *There was no accountability with the current processes for medication error investigation and follow-up. -That was a "gross error on my part." Review of the December 2023 Medication Administration policy revealed "D. Medication errors will be reported to the Licensed Nurse (or Executive Director where applicable) immediately. The resident's physician and family will be notified in a timely manner."	S 681	All residents who self administer meds will have a quarterly assessment completed by an RN. RN will monitor on a monthly basis x 3 months on 5 random self administration residents and then every 3 months therafter to ensure compliance, to include reporting to primary care provider. This will be reported to the QA Committee on a monthly basis.	
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued	S 685	Will review P&P with all residents who self administer medications including resident 8 & 9 to ensure understanding with signed acknowledgement. Quarterly assessment will be completed on Resident 8&9, as well as all residents who currently self admin. medications.	4-21-24

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S 685	Continued From page 29 appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review and policy review, the provided failed to ensure that the self-administration assessments were being completed every three months for two of two sampled residents (8 and 9). Findings include: 1. Interview on 3/4/24 at 3:32 p.m. with residents 8 and 9 regarding self-administration revealed: *They were husband and wife and were admitted on 11/30/21. *They had been self-administering since their admission to the facility. *Resident 8 had insulin injections scheduled four times a day. *Resident 9 stated they had a monthly medication sheet they would have to fill out after taking their medications and the facility would come back after that month and pick up the medication sheets. *Resident 8 stated resident 9 was assisting him to fill his pill box every Sunday and when they were finished he would initial the medication sheets on those Sundays. 2. Review of resident 9's self-administration	S 685		

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S 685	Continued From page 30 assessment revealed on: *11/03/22, 12/15/22, 9/5/23 they were completed. 3. Review of resident 8's self-administration assessment revealed on: *11/30/21, 1/12/22, 12/15/22, 9/5/23 they were completed. 4. Interview on 3/7/24 at 11:35 a.m. with clinical services director (CSD) B regarding the above observation revealed she: *Had given all the assessments that were in the resident's charts. *Agreed the self-administration assessments were not completed consistently every three months. 5. Review of the providers December 2023 Self-Administration policy revealed: "Clinical services will provide for initial and ongoing evaluation of the resident's ability to self-administer safely, in review (of capability and medications) per state regulations on the approved assessment form."	S 685		
S 701	44:70:08:01(1-6) Record Service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician assistant's, or nurse practitioner's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident	S 701	To ensure reporting to all staff members and documentating the care and individual needs are met when a change of condition occurs, all change of conditions will include a note in resident charts with a notation that a message was sent to the staff on the change of condition. Education will be provided to staff who document cares and needs of residents our documentation expectations to include a note in the electronic record. 5 change of conditions will be monitored on a monthly basis by Clinical Serv. Dir. for 3 months to ensure proper documentation has been sent to staff, then x 2 months and monthly therafter. This will be communicated by our CSD to our QA committee.	4/21/24

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S 701	Continued From page 31 physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record reviews, and policy review, the provider failed to ensure reporting to staff members and documenting the care and individual needs in the enhanced memory unit (EMU) for one of one sampled resident (10) after returning from the emergency department (ED). Findings included: 1. Observation and interview on 3/4/24 at 10:27 a.m. on the EMU revealed: *Resident 10 was sitting in her wheelchair (w/c) with her legs crossed watching television. *Resident 10's right eye and forehead were black and blue with a bandage on her forehead above her right eye, her hands and part of her forearms were also black and blue. *When asked what had happened to resident 10, certified medication aide (CMA) N stated she thought it was from a fall but she could call a registered nurse (RN) to follow up. *CMA N asked personal care assistant (PCA) O and she was unsure what happened to resident 10. - CMA N was reviewing on her computer to see if she had gotten any messages from any RN's about resident 10. *PCA O was reviewing the units communication book and on 2/29/24 it read that resident 10 went	S 701		

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S 701	Continued From page 32 to the ED. *RN K arrived on the EMU and stated resident 10 rolled out of bed and went to the ED. -She stated the process was that when a resident came back from the ED, the RN on duty would get a report from the ED and then the RN would send a message to all the CMA's and they would have the responsibility to let the PCAs know how to care for the resident who came back from the ED. -She was unsure why the RN on duty that day had not messaged the CMA's when the resident returned from the ED. The RN's were to message the CMA's with all new orders. -She was unsure if it was a policy but more of a courtesy to the rest of the team to let them know when a resident returned to the facility even if there were no new orders. 2. Review of resident 10's 3/1/24 care plan revealed: *Diagnoses included memory impairment, Alzheimer's and Dementia, atherosclerosis of aorta, benign hypertension, arthritis bilateral knees, depression, repeated falls, and anxiety. *Level of care was a 3, indicating directed care, was unable to call for assistance, unable to make sound judgement or self-direct care. *Reason for initiation of services: medication management, and falls. *Activities of Daily Living (ADL) "needs-bed-independent with bed mobility". *ADL "needs-transfers-needs help with transfers (one person assist)". *ADL "needs-toileting needs-needs help to use the bathroom through the day and night". 3. Review of resident 10's electronic medical record (EMR) regarding the 3/1/24 fall revealed she:	S 701		

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S 701	Continued From page 33 *Was transported to the ED at 2:40 a.m. -Was found lying on her right side and it appeared she had rolled out of bed and onto her bedroom floor. -Had three falls in the last 90 days. *Complained of her left hand, bilateral knees and chest pain. *Had a large laceration on her right forehead that was bleeding. 4. Interview on 3/5/24 at 12:15 p.m. with clinical services director (CSD) B revealed: *She received a call from a staff member on 3/1/24 at 2:47 a.m. regarding resident 10's fall and her head injury and she informed the staff member to send the resident to the ED. *They had a head injury policy but resident 10 was in the ED longer than their policy stated to monitor the resident. *They had been having a clinical services meeting once a month that included all RNs, licensed practical nurses (LPNs), PCAs, CMAs, and the biggest complaint was communication. *Her expectation was for the nurse on duty to send a message to all the CMAs with any updates regarding resident 10 when she returned from the ED. 5. Review of the provider's December 2023 Assessment policy revealed: *"Best Practive Guidelines for Evaluating a Change in Condition: (Nursing Process)" *"Assess, Diagnose, Plan, Implement, Evaluate" -"11. Communicate care modifications and expectations to staff."	S 701		
S1039	44:70:10:32 Electrical Distribution System A facility with 17 beds or larger shall be equipped	S1039		

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S1039	Continued From page 34 with an emergency electrical service that includes an automatic generator set and automatic transfer switches serving emergency panels. A facility with 17 beds or larger shall have automatic emergency lighting for each exit way, staff work areas, dining room, medication room, dietary department, medication room, room where main entrance electrical panels are located, boiler room, and exterior lighting serving required exits. A facility with 17 beds or larger shall have automatic emergency power for the fire alarm system, electrical receptacle servicing computers containing resident care records, telephone system, door alarms, and staff call system. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on record review and interview, the provider failed to maintain the generator as required (document the generator battery conductivity monthly, generator battery positive terminal cover, replace the generator battery). Findings include: 1. Record review on 3/5/24 at 11:00 a.m. revealed there was not documentation of the battery conductivity in the monthly maintenance logs for the generator. Interview with the maintenance supervisor at the time of the record review confirmed that finding. He stated he was checking the battery voltage but had not been documenting those figures monthly as required. 2. Observation on 3/5/24 at 11:15 a.m. revealed the generator battery did not have a cover on the positive terminal. The battery could be shorted out under certain conditions without the terminal protection. 3. Observation on 3/5/24 at 11:15 a.m. revealed	S1039	Generator battery will be replaced every 30 months or sooner if issues are identified. Generatory battery has been replaced as identified. Cover on the positive terminal of generator battery has been installed. Emergency lighting in the cave and boiler room has been installed. All Emergency lighting fixtures will be checked to see if activation occurs. This will be checked on a monthly basis and brought to the QA committee by the Maintenance director on a monthly basis. Battery conductivity figures will be documented monthly on maintenance log. Audit of monthly battery conductivity log will be brought to the monthly QA committee by the Maintenance Director.	4/21/24

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S1039	Continued From page 35 the generator battery had a date of 3/20 marked on it making it 48 months old. Generator batteries must be replaced at 24-30 months of age. 4. Interview with the maintenance supervisor at the times of the above observations confirmed those findings. The deficiency affected three of numerous requirements for generator maintenance. B. Based on observation and testing, the provider failed to maintain emergency lighting in two randomly observed locations (the cave and the boiler room). Findings include: 1. Observation on 3/5/24 at 10:45 a.m. of the storage space encompassing the hill adjacent to the building (the cave) was used for storage of noncombustible items. The storage space would be accessed by staff from the corridor but had no emergency lighting in the storage area 2. Testing on 3/5/24 at 10:50 a.m. of the battery pack emergency light in the boiler room by the garage revealed it would not activate. 3. Interview with the maintenance supervisor at the times of the above observations confirmed those findings.	S1039		

South Dakota Department of Health

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{S 000}	Compliance Statement An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 4/24/24 for deficiencies cited on 3/7/24. All deficiencies have been corrected, and no new noncompliance was found. Edgewood Spearfish Senior Living LLC is in compliance with all regulations surveyed.	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE