South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 11051 | A. BUILDING: _____ B. WING _____ | C 11/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GARDEN HILLS ASSISTED LIVING | 905 S. 34TH STREET SPEARFISH, SD 57783 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Compliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/12/24 through 11/13/25. Garden Hills Assisted Living was found not in compliance with the following requirements: S130, S200, S275, S280, S285, S350, S352, S400, S415, S450, S465, S474, S821, S838, and S845.<br><br>A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/12/25 through 11/13/25. Areas surveyed included potential resident abuse related to activities of daily living and potential resident-to-resident verbal abuse and misappropriation of property related to staff opening residents' mail, food quality, housekeeping, and staff assistance with bathing. Garden Hills Assisted Living was found not in compliance with the following requirements: S821 and S838. | S 000 | | |
| S 130 | 44:70:02:09 Infection Prevention And Control<br><br>The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. | S 130 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Dobson

TITLE: Administrator

(X6) DATE: 12/16/2025

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| S 130 | Continued From page 1<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider was unsuccessful in following infection control procedures and practices by having failed to:<br>*Assign a staff member to implement and oversee an infection control program.<br>*Properly monitor and report infections.<br>*Properly dispose of biohazardous sharps (needles and other sharp medical tools that could transmit diseases through blood or body fluids) containers (specialized containers designed to safely store and dispose of contaminated items with sharp edges).<br>*Ensure appropriate glove use by two of two caregivers/certified medication aides (CMAs)/cooks (D and H) during medication administration.<br>Findings include:<br><br>1. Observations and interviews conducted on 11/12/25 at 9:30 a.m. and again at 10:00 a.m. with caregivers/certified medication aides (CMAs)/cooks (D and H) in buildings one and two of the facility regarding the storage and disposal of sharps containers revealed:<br>*Each of their medication carts had a sharps container in the bottom drawer.<br>*They both confirmed that when a sharps container was full, it was to be placed in a biohazard bag (a special red bag used to transport sharp, contaminated items safely) and given to director C for disposal.<br>*Both caregiver/CMA/cook D and H were unsure of where the full sharps containers were disposed of by director C, and whether there was a policy and procedure for the staff to follow. | S 130 | | |

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| S 130 | Continued From page 2<br><br>2. Observation and interview on 11/12/25 at 12:20 p.m. with caregiver/CMA/cook H during medication administration revealed:<br>*Caregiver/CMA/cook H entered the medication storage room without performing hand hygiene, unlocked the medication cart, and prepared resident 8's medication.<br>*She administered the medication to resident 8, returned to the medication cart, and documented the administration in resident 8's medication administration record (MAR).<br>*She did not perform hand hygiene before or after the medication administration process.<br>*She agreed that she should have performed hand hygiene before and after she completed resident 8's medication administration task.<br><br>3. Observation and interview on 11/12/25 at 2:30 p.m. with caregiver/CMA/cook D during medication administration revealed:<br>*Caregiver/CMA/cook D entered the medication storage room without performing hand hygiene, unlocked the medication cart, and prepared resident 1's medication.<br>*She administered the medication to resident 1, returned to the medication cart, and documented the administration in resident 1's MAR.<br>*She did not perform hand hygiene before or after the medication administration process.<br>*She agreed that she should have performed hand hygiene before and after she completed resident 1's medication administration task.<br><br>4. Interview on 11/12/25 at 2:55 p.m. and again on 11/13/25 at 2:15 p.m. with director C regarding infection control procedures and practices revealed:<br>*The facility lacked an active infection control program, and no one had been appointed as an infection control preventionist to oversee it. | S 130 | | |

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

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| S 130 | Continued From page 4<br>*She confirmed that the facility had not regularly monitored or reported infections through QAPI or staff meetings.<br>*She confirmed there was no policy for the disposal of the sharps containers.<br>*Her expectation would have been for staff to wash their hands or use hand sanitizer before, after, and between residents during the medication administration process.<br><br>6. Review of the provider's revised June 2014 Proper Technique for Handwashing policy revealed:<br>*"Policy: All employees will know and follow proper handwashing techniques."<br>*"Procedure:<br>1) Turn on water<br>2) Wet your hands<br>3) Liquid Soap<br>4) Lather and scrub for at least 20 seconds ("Happy Birthday to me")<br>5) Leave water running while you dry hands completely with paper towel<br>6) Use same paper towel to turn off the faucet and then throw away (don't continue to dry hands)."<br>*"Washing Hands:<br>-Initially when coming to work<br>-Before and after each resident contact<br>-Before and after putting on gloves<br>-Before, during and after the preparation of food<br>-After using the toilet<br>-After smoking<br>-After blowing your nose, coughing, sneezing<br>-After any accidental contact with blood or body fluids."<br><br>7. Review of the Centers for Disease Control and Prevention website (CDC.gov) (a United States national health authority website) on "Clinical | S 130 | | |

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| S 130 | Continued From page 5<br>Safety: Hand Hygiene for Healthcare Workers" dated February 27, 2024, revealed the following information:<br>*"1. Wet hands with water."<br>*"2. Apply the manufacturer-recommended amount of product to your hands."<br>*"3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers."<br>*"4. Rinse hands with water and use disposable towels to dry. Use a clean disposable towel to turn off the faucet."<br><br>An infection control policy was requested on 11/12/25 from director C, and the only infection control policy provided was the provider's revised January/2023 'Covid-19/Additional Cleaning, Disinfecting Infection Control Procedures' policy. It revealed:<br>*There had been no mention of oversight by a designated staff member for the infection control program or for ensuring infection control procedures and practices were followed to monitor and report infections.<br><br>8. On 11/13/25 at 2:00 p.m., a sharps disposal policy was requested from director C.<br><br>9. On 11/13/25 at 2:55 p.m., director C stated they did not have a sharps disposal policy.<br><br>Refer to S400. | S 130 | *The facility will designate a healthcare personnel to be responsible for the implementation of the infection prevention and control program. The designee will also be responsible for monitoring and reporting infections, proper disposal of sharps containers and ensuring proper glove use and hand hygiene while administering medication.<br>*Policies and procedures for disposal of sharps containers will be created.<br>*Policies and procedures for handwashing will be updated.<br>*(RN) K will reeducate two of two CMAs D and H on proper hand hygiene while administering medication.<br>*All staff will be educated on the new and updated policies and procedures.<br>*Proper hand hygiene while administering medication will be monitored and tracked weekly in QAPI meetings by (RN) K, Director C and Administrator A for 4 weeks, then once a month for 3 months, then once quarterly until 100% compliance. | 12/28/2025 |
| S 200 | 44:70:03:01 Fire Safety Code Requirements<br><br>Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility | S 200 | | |

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| S 200 | Continued From page 6<br>unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation and interview the provider failed to continuously maintain egress free of obstructions that would prevent its use to a public way for one of three observed facility exit doors (western hallway exit).<br><br>Findings include:<br>1. Observation on 11/12/2025 at 10:45 a.m. with maintenance supervisor B in the western hallway revealed that one hallway exit door at the west end which had an exterior elevated concrete landing with steps which led to an unimproved (dirt/grass surface) area adjacent to the back yard and did not have any connecting sidewalks to a public way.<br><br>Interview with maintenance supervisor B on 11/12/2025 at 10:45 a.m. at the time of the observation confirmed those findings. | S 200 | *Owner/Maintenance Supervisor B is working with a contractor to create a ramp connecting access to a public way from western exit. | 12/28/2025 |
| S 275 | 44:70:04:01 Governing Board<br><br>Each facility operated by a limited liability partnership, a corporation, or a political subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or | S 275 | | |

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| S 275 | Continued From page 7<br>partnership shall carry out the functions in this chapter pertaining to the governing body.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview and policy review, the governing body failed to ensure the facility was administered in a manner that ensured the daily overall management, resident care, and resident safety was in compliance with the administrative rules of South Dakota, 44:70, Assisted Living Centers regulations for:<br>*Infection prevention.<br>*Background checks.<br>*Resident admissions.<br>*Nursing policies and procedures.<br>*Resident care for outside services.<br>*Dietetic Services.<br>*Food supply.<br>*Written dietetic policies.<br>*Residents' privacy and confidentiality.<br>*Resident quality of life.<br>*Grievances.<br><br>Findings included:<br><br>1. Interview on 11/13/25 4:49 p.m. with owner/administrator A regarding her role as the administrator revealed that she had assumed ownership of the facility in July 2022 and was the full-time administrator. She stated she had no prior experience working in an assisted living center (ALC) before assuming ownership of the facility and had relied on the previous ALC advisor for guidance. She was responsible for "fixing things", "helping director C", "putting out small fires", "making relationships", and "making people happy". | S 275 | | |

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| S 275 | Continued From page 8<br>The governing body was composed of owner/administrator A, owner/maintenance supervisor B, and director C.<br><br>The governing body was interviewed for these areas of deficient practice that were identified and referred to above as areas of concern.<br><br>Review of the provider's June 2025 Quality Assurance policy revealed:<br>"Procedure: The QA team will meet weekly or quarterly for ongoing evaluation of the quality of services provided to the resident's and staff these facilities."<br>"Components of the QA evaluation shall include:<br>-Establishment of facility standards<br>-Review of resident's services to identify deviations from the standards and actions to be taken to correct<br>-Resident satisfaction<br>-Utilization of services provided<br>-Documentation of evaluation"<br><br>Refer to S130, S285, S350, S352, S400, S415, S450, S465, S474, S821, S838 and S845 | S 275 | *The governing body will hold and document monthly QA meetings to ensure the facility is administered in a manner that overall management, resident care and resident safety is in compliance with Administrative Rules of South Dakota, 44:70, Assisted Living Centers.<br>*Weekly QAPI meetings will be held and documented by Owner/Administrator A, Director C and (RN) K to assist and ensure additional compliance with activities of daily living, resident quality of life, infection prevention and grievances. | 12/28/2025 |
| S 280 | 44:70:04:02 Administrator<br><br>The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. | S 280 | | |

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| S 280 | Continued From page 9<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview, the administrator failed to ensure the facility was managed in a manner to ensure:<br>*A process was established and maintained to verify that the individuals hired did not have a history of abuse or neglect.<br>*Nursing assessment and documentation had been completed.<br>*Residents were free from abuse.<br>*The residents had privacy and confidentiality related to unopened mail.<br>Findings include:<br><br>1. Interview on 11/13/25 at 2:40 p.m. with owner/administrator A regarding her role with new hires revealed:<br>*She had not established or maintained a process to verify if newly hired individuals had a history of abuse or neglect.<br>*She was unaware that verification of abuse or neglect for newly hired individuals was a requirement.<br>*She confirmed that employees C, D, G, H, and I had no background check or other form of documentation in their personnel files to verify they had no history of abuse or neglect.<br><br>2. Interview on 11/13/25 at 4:49 p.m. with owner/administrator A regarding her role as the administrator revealed:<br>*She assumed ownership of the facility in July 2022 and was the full-time administrator. She stated she had no prior experience working in an assisted living center (ALC) before assuming ownership of the facility and had relied on the previous ALC advisor for guidance. She was responsible for "fixing things", "helping director | S 280 | | |

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| S 280 | Continued From page 10<br>C", "putting out small fires", "making relationships", and "making people happy".<br>*She agreed that the facility would benefit from increased registered nurse (RN) hours, but confirmed she was not actively advertising for an RN to provide additional coverage.<br>*She had completed the same abuse training as the direct care staff.<br>*She was unaware of any incidents of abuse in the facility.<br>*The facility would have held the mail for families of the resident when requested but was unaware if the resident knew that their mail was being held.<br>-She stated that she had once accidentally opened some of the residents' mail.<br><br>A copy of the administrator;s job description was requested from director C on 11/13/25 at 3:30 p.m., but was informed there was no such job description.<br><br>Refer to S285, S350, S352, S821, and S838 | S 280 | *Owner/Administrator A will perform background checks on all current employees and establish a process for all new employees.<br>*Policies and procedures for background checks will be created.<br>*Administrator job description will be created.<br>*Policies and procedures for evaluation of needs will be created.<br>*Owner/Administrator A, Director C and (RN) K will track resident assessments and documentation through weekly QAPI meetings.<br>*Owner/Administrator A and (RN) K will hold and document monthly resident awareness meetings. Changes, reminders and happenings will be addressed on the administration side of things and residents can address any questions or concerns.<br>*Policies and procedures for resident awareness meetings will be created.<br>*All staff and residents will be reeducated on resident rights.<br>*All staff will be educated on new and updated policies and procedures. | 12/28/2025 |
| S 285 | 44:70:04:03 Personnel<br><br>The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Personnel on duty must be awake at all times, except as provided in § 44:70:03:02.01. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or personnel on contract. | S 285 | | |

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

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GARDEN HILLS ASSISTED LIVING | 905 S. 34TH STREET SPEARFISH, SD 57783 |

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| S 285 | Continued From page 12<br>they had no history of abuse or neglect.<br><br>4. On 11/13/25 at 2:00 p.m., a background check policy was requested from director C, and she stated that they did not have one.<br><br>Refer to S400 | S 285 | *Owner/Administrator A will perform background checks on all current employees and establish a process for all new employees.<br>*Policies and procedures for background checks will be created.<br>*All staff will be educated on new policies and procedures.<br>*Background checks will be monitored and tracked by Owner/Administrator A, Director C and (RN) K weekly in QAPI meetings until 100% compliance. | 12/28/2025 |
| S 350 | 44:70:04:13 Resident Admissions<br><br>Before admission to a facility, each resident shall have written orders from a physician, physician assistant, or nurse practitioner of symptoms and diagnoses and a physical examination certifying the resident is in reasonably good health.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on care record review and interview, the provider failed to ensure a physical exam and written orders were in place at the time of admission for one of two sampled residents. Findings include:<br><br>1. Review of resident 3's medical record revealed:<br>*She was admitted to the facility on 3/13/25.<br>*There was no documentation of a physical exam by a primary care provider (PCP) on admission.<br>*There was no documentation of any orders on admission.<br><br>2. A copy of resident 3's admission physical exam and admitting orders was requested from director C on 11/13/25.<br><br>3. Interview and record review on 11/13/25 at 3:13 p.m. with director C revealed:<br>*She stated they did not have documentation of a | S 350 | | |

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| S 350 | Continued From page 13<br>physical exam or orders for resident 3 at the time of her admission.<br>*She said, "I guess I just don't know what I need for an admission. I've just been told I need these forms," and provided this surveyor with two documents to review.<br>-The first document was the 2012 Assisted Living Center Optional Services and Practitioner Review form, which was signed by a physician assistant (PA) and indicated that resident 3 was appropriate for admission to an assisted living facility.<br>--The most recent version of that form has been retired since 2019.<br>*The second document was a Resident Admission Form, signed by a PA, which contained:<br>-The resident's name.<br>-An area labeled "Diagnoses," which was blank.<br>-An area labeled "Medications," in which "see attached" was written. No attachment was provided for review.<br>-A list of statements with blanks to check either "Yes" or "No" that indicated the resident was appropriate for assisted living, was free from communicable disease, needed supervision with medication, had a regular diet, had not had a TB (tuberculosis) test in the previous year, and had received the pneumococcal [a serious bacterial infection] vaccine.<br>-An area to indicate the "Date of last Physical Evaluation," which was 10/2/24.<br>*She confirmed that on admission, they did not have any orders on how to care for this resident, indicating what services and medications they should provide.<br>*Director C said that resident 3 wanted to change primary care providers so she would not have to travel back and forth from Spearfish to Rapid City for appointments. | S 350 | | |

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| S 350 | Continued From page 14<br><br>*She said resident 3 was discharged from another facility and arrived with medications, so they just continued to give her the medications she arrived with until she was seen by a PCP 12 days later.<br>*Resident 3 was seen and examined on 3/25/25 by a provider located closer to the facility, and orders for resident 3 were written.<br>*Registered nurse (RN) K noted those orders on 4/10/25, 16 days later.<br><br>4. An Admissions Policy and Procedure was requested from director C on 11/13/25 at 11:30 a.m. The facility did not have an Admissions Policy or Procedure.<br><br>5. Continued interview and record review on 11/13/25 at 3:18 p.m. with director C revealed:<br>*She said, "This is as close to a policy as we have," and gave this surveyor the provider's June 2014 "SD DOH Assisted Living Center Optional Services and Practitioner Review form."<br><br>Review of that form revealed:<br>*"Policy: A SD DOH form will be completed and signed by Physician on--<br>Admission<br>Significant change return to facility<br>Annually --- 12 calendar months"<br>*"Procedure: Admitting staff will contact potential resident's Physician and send copy of SD DOH form for completion and signature.<br>If current resident has significant change in status upon return to facility after rehab or hospital stay, a new SD DOH form will be sent to Physician for completion and signature.<br>If resident does not have any medical issues requiring a Physician's office appointment through the year, a SD DOH form will be sent with resident on mandatory yearly Physician review | S 350 | *Policies and procedures for resident admissions will be created.<br>*Policies and procedures for evaluation of needs will be created.<br>*Facility shall evaluate and document the residents care needs at the time of admission, thirty days after admission, and annually thereafter.<br>*Owner/Administrator A, Director C and (RN) K will track resident needs assessments and documentation through weekly QAPI meetings.<br>*All staff will be educated on new policies and procedures. | 12/28/2025 |

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| S 350 | Continued From page 15<br>appointment for completion and signature."<br><br>Refer to S400. | S 350 | | |
| S 352 | 44:70:04:13 Resident Admissions<br><br>The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on care record review and interview, the provider failed to ensure an evaluation of needs was completed 30 days after admission, for one of six sampled residents (3).<br><br>Findings included:<br><br>1. Review of resident 3's care record revealed:<br>*She had an admission date of 3/13/25.<br>*Her admission evaluation of needs was completed on 3/22/25.<br>*There was no documentation that her 30-day evaluation of needs had been completed.<br><br>2. Interview on 11/13/25 at 11:17 a.m. with director C regarding resident 3 revealed:<br>*She confirmed that there was no documentation that resident 3's 30-day evaluation of needs was completed.<br>*She stated it was her and registered nurse (RN) K's responsibility to have completed all evaluations of needs for the residents. | S 352 | | |

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| S 352 | Continued From page 16<br><br>3. Interview on 11/13/25 at 4:45 p.m. with owner/administrator A revealed:<br>*She stated it was the responsibility of RN K to have completed an evaluation of needs for the residents.<br>*She expected RN K to track the assessments and know when they are due.<br><br>4. An evaluation of needs policy was requested from director C on 11/13/25 at 3:30 p.m. She stated there was no such policy.<br><br>Refer to S400. | S 352 | *Policies and procedures for evaluation of needs will be created.<br>*Owner/Administrator A, Director C and (RN) K will track resident assessments and documentation through weekly QAPI meetings until 100% compliance. Monitoring and tracking will occur monthly indefinitely there after as we will be monitoring for annuals and/or change of needs.<br>*All staff will be educated on new policies and procedures. | 12/28/2025 |
| S 400 | 44:70:05:01 Nursing Policies And Procedures<br><br>The facility shall establish and maintain policies and procedures that provide nurses and other healthcare personnel with methods of meeting the facility's administrative and technical responsibilities in providing care to residents. The policies must include:<br><br>(1) The noting of diagnostic and therapeutic orders;<br>(2) The assignment of the nursing care of residents;<br>(3) Administration and control of medications;<br>(4) Assessment and documentation by nurses;<br>(5) Documentation by healthcare personnel;<br>(6) Infection control;<br>(7) Resident safety;<br>(8) Delineation of orders from nonphysician practitioners; and<br>(9) Activities of daily living to maintain each resident's physical functioning and personal care. | S 400 | | |

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| S 400 | Continued From page 17<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on a review of the provider's operating policies and procedures manual and interviews, the provider failed to establish and maintain policies and procedures for the facility personnel to fulfill responsibilities in providing care to residents.<br>Findings include:<br><br>1. Review of the provider's operating policies and procedures manual, along with requests made during the survey on 11/12/25 and 11/13/25, revealed that the facility did not have and could not provide the following policies and procedures.<br>-Food storage policy<br>-Pneumonia vaccine policy<br>-Influenza vaccine policy<br>-Evaluation of resident needs [annual] policy<br>-Hospice policy<br>-Emergency food supply policy<br>-Admission policy<br>-Provision of care policy<br>-Administrator job description policy<br>-Cognitive screen policy<br>-Resident personal mail policy<br>-Sharps disposal policy<br>-Background check policy<br><br>2. Interview on 11/12/25 between 10:35 a.m. and 11:30 a.m. with caregiver/CMA/cook E in the kitchen revealed:<br>*There were no dietary policies in the kitchen for staff to utilize.<br>*Caregiver/CMA/cook E stated "the policy book was in director C's office."<br>-She was unsure whether the kitchen department had many policies for staff use.<br><br>3. Interview on 11/13/25 at 1:50 p.m. with | S 400 | | |

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| S 400 | Continued From page 18<br>caregiver/CMA/cook J in the kitchen revealed:<br>*She was unsure where the dietary policies and procedures were kept for staff to utilize.<br>*She confirmed that there were no dietary policies in the kitchen for staff to follow.<br><br>4. Interview on 11/12/25 at 2:55 p.m. and again on 11/13/25 at 2:15 p.m. with director C revealed:<br>* She stated, "Facility policies are needed for everything," and, "I have a copy of the state regulations but have no policies for many things."<br><br>5. Interview on 11/13/25 at 9:25 a.m. and again at 2:40 p.m. with owner/administrator A revealed:<br>*The facility refers to the state regulations for assisted living centers as guidance.<br>*She stated, "My mind was not on trying to make our own, but to follow the state regulations."<br>*She confirmed that the facility had been using the policies and procedures the prior owner had used.<br>*She confirmed that she had not updated or created new policies and procedures for the facility since taking over ownership in July 2022, and they had not been reviewed and updated each year. | S 400 | *Policies and procedures will be created for the following:<br>-Food storage policy<br>-Pneumonia vaccine policy<br>-Influenza vaccine policy<br>-Evaluation of resident needs policy<br>-Hospice policy<br>-Emergency food supply policy<br>-Admission policy<br>-Provision of care policy<br>-Administrator job description policy<br>-Cognitive screen policy<br>-Resident personal mail policy<br>-Sharps disposal policy<br>-Background check policy<br>-Policies and procedures for dietetic services will be updated.<br>*A copy of all dietary policies along with dietary training and continuing education will be kept in the kitchen at all times.<br>*All staff will be educated on new and updated policies and procedures. | 12/28/2025 |
| S 415 | 44:70:05:03 Resident Care<br><br>The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean | S 415 | | |

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| S 415 | Continued From page 19<br>and healthy.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview, care record review, and job description review, the provider failed to ensure that the individual care needs for one of one sampled residents (4) had been assessed and documented by licensed nursing staff related to her health status and mental health needs.<br><br>Findings include:<br><br>1. Interview on 11/12/25 at 10:08 a.m. with resident 4 in her room revealed:<br>*She wanted someone to talk to about her mental health issues.<br>*When she talked to director C about this, director C said that she had offered three times to get someone for her to talk to, but resident 4 had declined all three times.<br>*Resident 4 stated, "That is not true. I would like to have someone, like a counselor, to talk to."<br><br>2. Review of resident 4's care record revealed:<br>*She had a 2/27/23 Nursing Home Progress Note that indicated she had a Mini-Mental State Examination (MMSE) score of 20/30, which indicated mild cognitive impairment.<br>*That same progress note indicated she had Type 2 diabetes and had been taken off a diabetic diet with the plan to "Continue to monitor on regular diet as special diets are often a barrier to ALF [assisted living facility] admission. Consider repeat A1C [blood test that measures average blood sugar over the past two to three months] in April."<br>*Resident 4 was admitted to the facility on 3/7/23.<br>*The registered nurse had initialed that progress note, indicating she had read it. | S 415 | | |

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| S 415 | Continued From page 20<br>*There were no follow-up labs or progress notes to indicate her diabetes was being addressed or monitored in the care record.<br><br>*A 9/9/25 message from director C to resident 4's primary care provider (PCP) indicated that resident 4's sister/POA had requested counseling for resident 4 as she "seems to be more withdrawn."<br>-There was no documentation of a response from the PCP.<br>*There were no progress notes documenting resident 4's request for counseling or indicating that her mental health status was being monitored.<br>*There was no documentation to indicate there was any follow-up on that communication to her PCP.<br><br>Review of resident 4's Assisted Living Individualized Service Plan (ISP) revealed:<br>*It had been completed by director C on 8/8/23.<br>*There was a box that had a checkmark in it next to the statement "I have reviewed the ISP services as listed above and recommend the following change(s) in service:" which was followed by a blank area to indicate what changes had been recommended.<br>-In that blank area, "9/18/24" had been written.<br>*Director C had signed below that area and dated it 9/18/24.<br>*There was a section to list necessary lab testing in which "N/A" was written.<br>*There was a section to address mental health needs in which "N/A" was written.<br>*A registered nurse had signed the top of that Individualized Service Plan in 2023 and in 2024.<br><br>3. Interview on 11/13/25 at 11:58 a.m. with director C revealed: | S 415 | | |

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| S 415 | Continued From page 21<br>*The provider ordered labs, and the nurse just looked at the results.<br>*She confirmed that resident 4's diabetes was not addressed in the Individualized Service Plan and had not been assessed by the nurse.<br>*She said, "The nurse is on a learning curve, too. She doesn't really assess residents unless a significant change is identified by us."<br>*Regarding the counseling request, she said, "I know there was a referral made, but I don't have that in her chart. And then I talked to [resident 4] and she declined it."<br>-She confirmed that she had no documentation to support that.<br>*She confirmed that mental health needs were not addressed in the Individualized Service Plan and had not been assessed by the nurse.<br>*Caregiver/CMA G entered director C's office during the interview and stated she had just contacted the PCP and presented a referral to Behavioral Health/Psychology/Counseling for resident 4 that the PCP faxed to the facility, dated 11/13/25.<br><br>4. Interview on 11/13/25 at 4:49 p.m. with administrator A revealed that she thought it was a problem that a nurse was not regularly on the schedule. She stated she was not actively recruiting a full-time nurse.<br><br>5. Review of the Registered Nurse job description and contract revealed:<br>*"The role of the Assisted Living Senior Care Registered Nurse at [provider] is to ensure that the health and safety of all residents are met through assessments and reassessment, development and implementation of appropriate service plans and plans of care, monitoring of resident's services, supervision of all medical staff, Med aides and other medical staff if | S 415 | | |

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| S 415 | Continued From page 22<br>appropriate. The RN will provide necessary ongoing training of such staff and determine that they are competent prior to assigning them duties. The RN may appoint a designee, under their direction, to assist with some duties, but they must be appropriate in accordance with South Dakota compliance requirements.<br>The RN will also ensure that the facility is in compliance with current regulations and standards according to the SD 44:70. The RN will provide to the Administrator any necessary information to ensure the facility is in compliance with the SD 44:70. The RN will provide all of their necessary licensing required by the state of South Dakota."<br>*"Major duties:<br>-Complete initial, face-to-face comprehensive assessment of prospective new residents and develop a proposed service plan as needed<br>-Complete all admission paperwork, medication transfers, Dr orders, assessments, charting, and entering information into the PCC program or charts.<br>-Complete readmission of residents after hospital stays<br>-Monitor and reassess residents as per policy<br>-Facility coordination of resident's services with other service providers<br>-Ensure residents have up-to-date care plans that address their needs and preferences<br>-Assist with the development of policy, procedures and audits as needed<br>-Provide the Administrator the necessary audits and reports for compliance<br>-Assist the Administrator with annual staff reviews<br>-Other duties that the Doctor or Administrator may require regarding resident care or facility compliance"<br>*"Qualifications:<br>-Must receive a "non-disqualified" criminal | S 415 | *The facility will update the process for documenting failure to maintain appointments.<br>*Policies and procedures for evaluation of needs will be created.<br>*Policies and procedures for care plans will be created.<br>*Owner/Administration A, Director C and (RN) K will monitor and track care plans and resident needs assessments through QAPI meetings on a weekly basis until 100% compliance and monthly there after indefinitely to address future changes and assessments.<br>*All staff will be educated on new policies and procedures.<br>*The facility is not actively seeking a full-time RN because that is not financially an option, but we were actively in contact with another PT (RN) option. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GARDEN HILLS ASSISTED LIVING | 905 S. 34TH STREET SPEARFISH, SD 57783 |

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| S 415 | Continued From page 23<br>background result from the Department of Human Services and may not be on the OIG exclusion list."<br>-"Must have a working knowledge of state, federal and local regulations."<br><br>6. A care plan policy, resident needs assessment policy, and a policy addressing how care was provided to residents were requested from director C. She informed the survey team that none of the policies identified existed.<br><br>Refer to S400. | S 415 | | |
| S 450 | 44:70:06:01 Dietetic Services<br><br>The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider failed to ensure that foods were stored, handled, prepared, and served in a safe and sanitary manner related to:<br>*Inappropriate hand hygiene and glove use in building one of the kitchen for one of one caregiver/CMA/cook (E) while handling and serving food.<br>*Expired packaged food stored in building one of the food storage pantry.<br>Findings include:<br><br>1. Observations on 11/12/25 between 11:30 a.m. and 12:30 p.m. with caregiver/CMA/cook E during | S 450 | | |

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| S 450 | Continued From page 24<br>lunch service revealed:<br>*She washed her hands at the kitchen sink and dried them with a clean paper towel.<br>*She used the same wet, contaminated paper towel to turn off the kitchen faucet, wipe around the sink, and then serve drinks to residents in the dining room.<br>*She was wearing gloves and was plating and serving meals from the kitchen area.<br>*She used those same gloved hands to touch surfaces and utensils, including cupboard doors, bowls, plates, and tongs, and then directly touched ready-to-eat food items (saltine crackers).<br>*With those same gloved hands, she wiped her face/forehead on the back of her right arm and then resumed plating and serving meals without performing hand hygiene and putting on a new pair of gloves.<br><br>2. Observation and interview on 11/12/25 at 11:20 a.m. in building one of the food pantry with maintenance L revealed:<br>*Maintenance L was stocking the pantry with new food products that had been delivered.<br>*Maintenance L stated that he was responsible for stocking the food pantry with the newly delivered food products.<br>*He stated that he stocked the food pantry shelves by moving the existing food forward and then he would place the new food deliveries at the back.<br>-He stated the "back to front rotation" process was to ensure that older stocked food was placed at the front and used before the newer stocked food, which was placed behind when delivered.<br>*Observation of the food products in the pantry revealed the following:<br>*A 26.7-ounce box of Great Value instant potatoes with an expiration date of 11/6/25. | S 450 | | |

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| S 450 | Continued From page 25<br>*A 15-ounce bag of Victor raisins with an expiration date of 10/18/25.<br>*A 16-ounce jar of Great Value dry-roasted peanuts with an expiration date of 7/7/25.<br>*A 11-ounce box of Great Value vanilla wafer crackers with an expiration date of 4/12/25.<br>*Four 15-ounce boxes of Lion raisins with expiration dates of 10/4/24.<br>*Maintenance L confirmed that the food products listed above had expired, and he was unsure who was responsible for checking the food pantry for outdated items.<br>*Maintenance L immediately removed the items from the pantry.<br><br>3. Observation and interview on 11/12/25 at 11:30 a.m. with caregiver/CMA/cook E regarding food storage revealed:<br>*The night shift was responsible for checking the stocked food pantries, refrigerators, and freezers for outdates.<br>*She stated this was done once a month, and she was unsure if there was a tracking form that staff used to document their monthly checks.<br>*She was unsure if there was a policy for food storage.<br><br>4. Interview on 11/12/25 at 4:15 p.m. with director C regarding food storage revealed:<br>*She stated that the kitchen staff in buildings one and two were responsible for checking the stocked food pantries for expiration dates.<br>*She believed the night staff checked the food supply for outdates at least monthly.<br>*She agreed that the facilities' food supply should be regularly checked and tracked for expiration dates.<br>*She confirmed that the facility had no process for staff to track and document monthly food supply checks, and there was no food storage policy | S 450 | | |

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| S 450 | Continued From page 26<br>available.<br><br>5. Review of the provider's June 2014 Proper Techniques for Food Preparation policy revealed:<br>*"Procedure:<br>*"1) Wash hands following appropriate handwashing technique<br>*"..4) Wear gloves when preparing and serving ready-to-eat foods such as fresh fruits and vegetables, sandwiches, and salads<br>*"5) Use appropriate clean utensils to limit contact with foods that do not need to come in contact with hands<br>*"6) Change gloves between tasks<br>*".8) Change gloves after sneezing, wiping nose, touching own face or hair, or with contact with potentially contaminated surface, like refrigerator handle, drawer handle, or cupboard door."<br><br>6. Review of the provider's June 2014 Proper Food Serving Practices policy revealed:<br>*"Procedure:<br>*"1) Wash hands following proper handwashing techniques<br>*"2) Avoid touching ready-to-eat foods such as sandwiches, fresh fruit, vegetables, cookies, and bread."<br><br>7. On 11/12/25 at 4:15 p.m., a food storage policy was requested from director C, and she stated they did not have one.<br><br>Refer to S400 | S 450 | *Owner/Administrator A will reeducate Caregiver/CMA/Cook E on proper hand hygiene and glove use while handling and serving food.<br>*Policies and procedures for handwashing will be updated.<br>*Policies and procedures for food handling and preparation techniques will be updated.<br>*Policies and procedures for food storage will be updated.<br>*Owner/Administrator A and Director C will monitor and track proper hand hygiene and glove use while handling and serving food and food storage once a week for 4 weeks, then once a month for 3 months, then once quarterly until 100% compliance.<br>*All staff will be educated on new and updated policies and procedures. | 12/28/2025 |
| S 465 | 44:70:06:05 Food Supply<br><br>The facility shall maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned menus for three days. A | S 465 | | |

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| S 465 | Continued From page 27<br>facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat in an emergency event according to the facility's emergency response plan.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, menu review, and policy review, the provider failed to maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned emergency menus for three days.<br>Findings include:<br><br>1. Observation on 11/12/25 between 3:30 and 4:00 p.m. in buildings one and two of the two food pantries and menus revealed:<br>*There was no 3-day emergency food supply on-site.<br><br>2. Interview on 11/12/25 at 4:00 p.m. with caregiver/CMA/cook H regarding the emergency 3-day food supply revealed:<br>*She was unsure whether there was a 3-day emergency food supply at the facility and was unaware of where it would be stored if it was on-site.<br><br>3. Phone interview on 11/13/25 at 10:59 a.m. with registered dietician (RD) F regarding menus revealed:<br>*She visited the facility every month, completed resident nutritional assessments, and addressed any concerns.<br>*She stated that she completed annual training for the kitchen staff and for new hires.<br>*The facility menus were reviewed, updated, and | S 465 | | |

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| S 465 | Continued From page 28<br>signed every six months.<br>*She was unaware of a 3-day emergency menu for the facility.<br><br>4. Interview on 11/13/25 at 2:15 p.m. with director C and at 2:40 p.m. with owner/administrator A regarding the emergency 3-day food supply revealed:<br>*The facility census between buildings one and two was 27.<br>*They were unaware that a 3-day emergency food supply was required to be on-site.<br>*They were unaware that a 3-day emergency menu was required.<br>*They confirmed that there was no 3-day emergency menu or food supply, and that the facility had no policy in place for a 3-day emergency food supply.<br><br>5. On 11/12/25 at 4:15 p.m., an emergency food supply policy was requested from director C, and she stated they did not have one.<br><br>Refer to S400 | S 465 | Policies and procedures for emergency food supply will be created.<br>*The facility will maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned menus for three days.<br>*The facility shall maintain an additional supply of non perishable foods as part of the facility's emergency preparedness plan.<br>*The facility will prepare a three day emergency menu as well. | 12/28/2025 |
| S 474 | 44:70:06:08 Written Dietetic Policies<br><br>The facility shall have written policies and procedures that govern all dietetic activities. The policies and procedures must include food handling procedures, length of duration for leftovers, and opened packages of commercially prepared food in accordance with chapter 44:02:07. The facility shall review the policies and procedures yearly and revise as necessary.<br><br>This Administrative Rule of South Dakota is not met as evidenced by: | S 474 | | |

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| S 474 | Continued From page 29<br>Based on observation, interview, and record review, the provider failed to establish and maintain dietetic policies for kitchen personnel related to storage, labeling, and discarding of food to ensure safe and sanitary food environments in buildings one and two of the kitchens.<br>Findings include:<br><br>1. Observation and interview on 11/12/25 at 11:30 a.m. with caregiver/CMA/cook E in building 1 of the kitchen revealed:<br>*Inside the refrigerator, there was the following:<br>-An unlabeled Tupperware container holding an orange liquid, with a piece of masking tape on the lid marked 10/24/25.<br>-Caregiver/CMA/cook E stated that the container contained "Dorothy Lynch salad dressing."<br>-The container lacked a label and did not display a use-by date.<br>*She stated that she was trained to discard leftovers after three days.<br>*The container of "salad dressing" must have been overlooked and not discarded after three days.<br>*She confirmed there were no use-by dates on the leftover food items.<br>*Caregiver/CMA/cook E was unsure if there was a policy for opened and leftover foods.<br>*She was unsure whether the kitchen department had many policies for staff use.<br>*She removed the container from the refrigerator to discard it.<br>*There were no dietary policies in the kitchen for staff to utilize.<br><br>2. Interview on 11/13/25 at 2:00 p.m. with caregiver/CMA/cook G regarding food storage, labeling, and discarding policy revealed:<br>*After reviewing the provider's operating policies | S 474 | | |

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| S 474 | Continued From page 30<br>and procedures manual, she was unable to supply a policy for food storage, labeling, and discarding.<br><br>3. Interview on 11/13/25 at 2:15 p.m. with Director C and at 2:40 p.m. with Owner/Administrator A about a food storage, labeling, and discarding policy revealed that they confirmed there was no policy available for the facility.<br><br>4. On 11/12/25 at 4:15 p.m., a food storage policy was requested from director C, and she stated they did not have one. | S 474 | *Policies and procedures for food storage will be updated.<br>*A copy of all dietary policies and procedures along with all dietary training and continuing education will be kept in the kitchen at all times.<br>*All staff will be educated on the updated policies and procedures.<br>*All new and annual employee dietary education will be monitored and tracked weekly until 100% compliance after a new hire and after annual continuing education. | 12/28/2025 |
| S 821 | 44:70:09:08(1) Privacy And Condidentiality<br><br>A facility shall permit residents:<br><br>(1) To send and receive unopened mail and to have access to stationery, postage, and writing implements at the resident's own expense;<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on a review of the 4/22/25 South Dakota Department of Health (SD DOH) complaint intake form, observation, interview, and policy review, the provider failed to ensure residents' privacy and confidentiality by not protecting residents' unopened mail.<br><br>Findings include:<br><br>1. A review of the 4/22/25 SD DOH complaint intake form revealed that a confidential complainant had concerns that the residents' mail | S 821 | | |

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| S 821 | Continued From page 31<br>appeared to have been opened when they received it.<br><br>2. Observation on 11/12/25 at 9:47 a.m. in the dining room revealed that there was a sign posted on the bulletin board with the following message:<br>"Staff,<br>Please do not open or give any resident a package that is addressed to them.<br>ALL packages must be cleared thru [director C].<br>*Frequently [used] medical supplies that need stored in office<br>*Any envelopes that appear to be from a medical place also need checked"<br><br>3. Interview on 11/12/25 at 10:08 a.m. with resident 4 in her room revealed:<br>*Mail was usually delivered to residents at the tables during mealtimes.<br>*She confirmed that she had received mail that had been opened.<br><br>4. Interview on 11/13/25 at 2:22 p.m. with director C about the process for delivering mail revealed:<br>*All mail was delivered to a communal mailbox.<br>*Someone got the mail from the mailbox and put the mail on director C's desk.<br>*She would then "hand it out based on what it is."<br>*She said some family members had requested that director C hold the resident's mail until the family member could pick it up.<br><br>5. Interview on 11/13/25 at 4:49 p.m. with administrator A regarding the mail revealed:<br>*Director C got the mail and handed it out.<br>*She said, "We have some families who want us to hold the mail, and they pick it up."<br>-She gave an example, "Like if it's a bill," and the family member pays it. | S 821 | | |

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| S 821 | Continued From page 32<br>*She did not know whether residents were aware that they were not receiving their mail and that it was being held for a family member to pick up.<br>*She stated that she had accidentally opened some of the residents' mail.<br><br>6. Review of the provider's undated Resident Bill of Rights revealed:<br>*"As a resident of [provider], these rights will be respected and supported by the staff and management."<br>*"The right to exercise his/her rights as a resident of this home and as a citizen of the United States."<br>*"The right to be free of interference, coercion, discrimination, and reprisal from this home in exercising his/her rights."<br>*"The right to file a complaint with the South Dakota Department of Health concerning abuse, neglect, and misappropriation of resident's property. This home will provide the resident with the information necessary to file such a complaint."<br>*"The right to manage his/her own financial affairs."<br>*"The right to receive and send unopened mail." | S 821 | *All staff will be reeducated on the resident bill of rights.<br>*Policies and procedures for privacy and confidentiality will be updated.<br>*All staff will be educated on the updated policies and procedures.<br>*Owner/Administrator A and Director C will monitor and track the dispensing of mail once a week for 4 weeks, the once a month for 3 months, then once a quarter until 100% compliance. | 12/28/2025 |
| S 838 | 44:70:09:09(4) Quality Of Life<br><br>A facility shall provide care and an environment that contributes to the resident's quality of life, including:<br><br>4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; | S 838 | | |

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| S 838 | Continued From page 33<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on a review of the 11/6/25 South Dakota Department of Health (SD DOH) complaint intake form, 11/5/25 Department of Human Services' (DHS) Report of Suspected Dependent Adult/Elder Abuse, interview, care record review, and policy review, the provider failed to ensure two of two sampled residents (3 and 4) received care that contributed to their overall quality of life by ensuring:<br>*Resident 3 was free from verbal abuse and psychological harm by one of one director (C) and one of one caregiver (G).<br>*Resident 4 was free from verbal abuse and psychological harm by one of one director (C).<br><br>Findings include:<br><br>1. Review of the 11/6/25 SD DOH complaint intake form and the 11/5/25 DHS Report of Suspected Dependent Adult/Elder Abuse revealed:<br>*On 11/4/25, caregiver G was assisting resident 3 with a shower and told her that if she could put a pain patch on her shoulder, she could "wash herself," and declined to help the resident with washing.<br>*After the shower and while dressing, resident 3 asked caregiver G for help with pulling her pants up. Caregiver G responded by telling resident 3 to do it herself.<br>*Caregiver G then went into director C's office and told her about the resident's requests for assistance.<br>*Director C went to resident 3's room and told her that she needs to do things for herself, or she would put her in a nursing home. | S 838 | | |

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| | 11051 | A. BUILDING: _____ B. WING _____ | C 11/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GARDEN HILLS ASSISTED LIVING | 905 S. 34TH STREET SPEARFISH, SD 57783 |

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| S 838 | Continued From page 34<br>*Resident 3 became tearful and was upset for the rest of the day.<br>*The confidential complainant expressed concern and frustration about not being able to approach leadership for help because it is leadership that was exhibiting this behavior.<br>*The reports stated that this type of behavior/verbal abuse had also been witnessed with resident 4 and resident 5.<br><br>2. Interview on 11/12/25 at 3:02 p.m. with resident 3 revealed:<br>*She had been at the facility since March 2025.<br>*She had moved into an assisted living setting because she needed "help with some things," like getting her socks on and putting on her pants.<br>*She stated that most of the staff were very nice, but she did have a problem recently.<br>*She had asked caregiver G if she would pull her pants up. Caregiver G told her she could do it herself, "and she reported it to [director C]."<br>-Resident 3 was very confused by this and said, "Everybody else had helped me with my pants. I just can't believe she reported it."<br>*Director C then came into resident 3's room and told her that if she could not pull her pants up, she would "put me in a nursing home."<br>*Resident 3 said, "I'm sure my mouth literally dropped open. I just couldn't believe it."<br>*She asked, "Am I being petty? I just couldn't believe it."<br>*She said that episode upset her; she was "in shock" when it happened, she was angry about it, and "just mad." Then she asked again if she was being petty.<br>*She stated that caregiver G had not been in her room since that time.<br><br>3. Interview on 11/25/25 at 10:08 a.m. with an anonymous resident revealed: | S 838 | | |

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| S 838 | Continued From page 35<br>*She had been at the facility for a couple of years.<br>*When asked if the staff treated her with respect, she said, "Not really. There's one gal that makes you feel, well, she's just unkind."<br>*When asked to describe how she was unkind, the resident said, "She talks to me like I'm stupid."<br>*When asked how that made her feel, she said, "Exactly like it's supposed to. It makes me feel stupid."<br>*She identified that individual as director C.<br>*She said, "I don't know if [director C] just doesn't like me, or if she talks to others that way."<br>*She said, "I just don't know when she's going to start in on me, like I did something wrong."<br>*The resident said she had been thinking about contacting the ombudsman about the way director C talked to her, but she was not sure how to contact them.<br>*"I don't know how to explain the way she talks to me. She talks to us like we're children."<br><br>4. Interview on 11/13/25 at 2:22 p.m. with director C about abuse revealed:<br>*She had received education on abuse and neglect as part of the annual personnel training.<br>*She would view a wide range of actions as abuse: failing to meet residents' needs; unwillingness to care for residents; and not advocating for them.<br>-She said, "I don't witness that here."<br>*All staff members had received the same education on abuse and neglect.<br>*If she witnessed abuse by a staff member, she would send the staff member home, report it to the proper authorities, like the state, fill out an incident report, and carry out an investigation.<br><br>5. Interview on 11/13/25 at 3:12 p.m. with director C about the abuse policy that had been requested | S 838 | | |

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| S 838 | Continued From page 36<br>revealed:<br>*She said, "This is what we have for abuse," and provided:<br>-Their 2019 Policy for Reporting to SD DOH.<br>-The undated Resident Bill of Rights.<br><br>6. Interview on 11/13/25 at 4:49 p.m. with administrator A revealed:<br>*She had received education on abuse and neglect as part of the annual personnel training.<br>*When asked what she considers abuse, she said there could be several types of abuse that could include sexual, verbal, and physical abuse.<br>*If she witnessed abuse by a staff member, she would ask them to go home, assess the resident and the situation, contact law enforcement if appropriate, and then contact the nurse.<br>*She was not aware of any incidents of abuse in the facility.<br>*Regarding her working relationship with director C, she said she was "not really" providing guidance or mentoring her. "I think we just try and help each other."<br><br>7. Review of the 2019 Policy for Reporting to SD DOH revealed:<br>*"Policy: [provider] will conduct an investigation and report to the State Dept. of Health:"<br>-"Any incident that leads to injury of a serious nature:<br>a) In the event of an incident that leads to injury of a serious nature, director will be notified by staff involved.<br>b) An incident report will be completed by staff involved before the end of their shift.<br>c) Family and facility RN will be notified and updated on situation.<br>d) Director and/or supervisor will conduct investigation of incident and determine a conclusion if any abuse or neglect is suspected | S 838 | | |

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| S 838 | Continued From page 37<br>and report findings to administrator.<br>e) A plan of action will be determined to prevent this or similar incidents from happening to this or other residents in the future and will be executed.<br>f) Online report of incident will be submitted within 48 hours of known incident.<br>g) If there is any further investigation reporting that needs to be submitted after initial report, it will be completed within 5 working days as required."<br><br>8. Review of the undated Resident Bill of Rights revealed:<br>*"As a resident of [provider], these rights will be respected and supported by staff and management."<br>-"The right of freedom from verbal, sexual, physical, and mental abuse as well as from involuntary seclusion, neglect or exploitation imposed by anyone, and theft of personal property."<br><br>9. Review of the provider's 2024 Employee Education/Training on Elder Abuse revealed:<br>*"As people become older, they become more physically frail and unable to care for themselves. They are not able to stand up to bullying and they then become the victims of abuse."<br>*"Emotional/Verbal abuse: any act including confinement, isolation, verbal assault, humiliation, intimidation, infantilization, or any other treatment that may diminish the sense of identity, dignity, and self-worth. Yelling or swearing, Name calling or insults; mocking, Threats and intimidation, Ignoring or excluding, Isolating, Humiliating, Denial of the abuse and blaming of the resident. This may include joking at their expense, calling them by names other than their own, etc."<br>*"Neglect or Abandonment: Failing to fulfill a caretaking obligation. It can be intentional or | S 838 | | |

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| S 838 | Continued From page 38<br>unintentional, based on factors such as ignorance or denial that an elderly charge needs as much care as they do. Neglect is defined as harm to a person's health or welfare without reasonable justification. Caused by the conduct of someone responsible for the person's health or welfare, including offensive behavior made to or directed at a resident and the failure to provide timely, consistent, and safe services, treatment or care necessary to avoid physical harm, mental anguish or mental illness to that person. This can include failure to tend to incontinence, feeding or bathing."<br>*"Some signs and symptoms of abuse<br>-Withdrawal and apathy<br>-Nervous or fearful behavior, especially around the caregiver<br>-Strained or tense relationship between caregiver and elder<br>-Caregiver who is snapping or yelling at the elder"<br>*"If you suspect abuse of a resident or an employee, you MUST report it at once to the Administrator or the Nurse."<br>*"Any type of abuse or neglect of residents or employees is cause for immediate dismissal and will be prosecuted to the fullest extent allowed by law."<br>"Anyone knowingly who fails to make the required report is guilty of a Class 1 misdemeanor punishable by a maximum of 1 year imprisonment in county jail/a fine of $2000."<br><br>Refer to S400. | S 838 | *Director C and Caregiver G both received verbal warnings.<br>*(RN) K will reeducate Director C and Caregiver G on resident Abuse and Neglect as well as the resident bill of rights.<br>*Director C and Caregiver G both offered an apology to resident 3 with an explanation of goals of care conversations.<br>*Policies and procedures on grievances will be updated.<br>*All staff will be educated on the updated policies and procedures. | 12/28/2025 |
| S 845 | 44:70:09:10 Grievances<br><br>A resident or the resident's designated representative may voice grievances without discrimination or reprisal. A resident's grievance | S 845 | | |

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| S 845 | Continued From page 39<br>may be given in writing or verbally and may relate to treatment furnished, treatment that has not been furnished, the behavior of other residents, and infringement of the resident's rights. A facility shall adopt a grievance process and make the process known to each resident and to the resident's representative.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview and record review, the provider failed to ensure that a grievance process was established, implemented, and made known to 4 of 4 (7,4,5, and 3) sampled residents.<br><br>Findings include:<br><br>1. Interview on 11/12/25 at 9:50 a.m. with resident 7 revealed:<br>*She had been at the facility for about a month.<br>* She did not know who to discuss concerns with if she had them.<br>* She did not know if the facility had a process for complaints.<br><br>2. Interview on 11/12/25 at 10:08 a.m. with resident 4 revealed:<br>*She had been at the facility for about two and a half years.<br>*She was aware that she could contact the ombudsman if she had a concern, but she was not sure how to contact the ombudsman.<br>*She did not know if the facility had a process for residents to file a complaint or grievance.<br><br>3. Interview on 11/12/25 at 11:42 a.m. with resident 5 revealed:<br>*She had been at the facility for about a year.<br>*She did not know the process to follow to file a complaint or grievance. | S 845 | | |

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| S 845 | Continued From page 40<br><br>4. Interview on 11/12/25 at 3:02 p.m. with resident 3 revealed:<br>*She had been at the facility since March 2025.<br>*She would not know what to do if she had a concern or wanted to file a complaint.<br><br>5. Interview on 11/13/25 at 9:00 a.m. with director C revealed:<br>*She stated, "I guess we do have a grievance policy, but I didn't even know that was a thing."<br>*"We had a complaints box a few years ago, but it wasn't utilized."<br>*She confirmed that they did have a grievance policy, but they had no process in place for residents to be able to file a complaint or grievance.<br><br>6. Review of the provider's 9/2018 Grievance Policies and Procedures revealed:<br>*"Policy: All residents have access to a procedure for submitting grievances, comments and suggestions. These grievances may be written or oral. Each resident will be provided the address and phone number of the persons to contact for this process. The filing of a grievance will not jeopardize the resident's care."<br>*"Procedure:<br>1. If a resident has a concern or complaint and they discuss the grievance with the staff, the staff must report the concern or complaint to the supervisor or administrator.<br>2. Every effort will be made to resolve the problem informally and to the satisfaction of the resident.<br>3. If the grievance is not resolved, a formal grievance will be initiated. The supervisor or administrator will document and receive the formal grievance in writing or orally. This should include the nature of the problem, date of | S 845 | | |

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| S 845 | Continued From page 41<br>problem and the remedy sought by the resident. The grievance shall be reviewed by the administrator and a decision made in a 30-day period.<br>4. If the resident is not satisfied with the decision, the resident may appeal to the local ombudsman or the State Dept of Health-<br>Local Ombudsman #--Dan Frieden - 1-833-663-9673<br>State Dept of Health #--1-800-738-2301 OR 1 -605-773-3361" | S 845 | *Policies and procedures for grievances will be updated.<br>*All staff will be educated on the updated policies and procedures.<br>*All residents and/or resident's designated representative will be made aware of the grievance process at the time of admission.<br>*All residents and/or resident's designated representative upon admission will be made aware of the local ombudsman and how to contact them and where the information is posted in the facility.<br>*Facility will include grievance policy in education annually and upon hire.<br>*Residents will be educated annually on the grievance policy during resident awareness meetings. | 12/28/2025 |