STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A 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 4/22/25 through 4/23/25. Edgewood Greenleaf Sioux Falls LLC was found not in compliance with the following requirements: S105, S130, S165, S201, and S654. 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 4/22/25 through 4/23/25. Areas surveyed included elopement, physical environment, licensure (over level of care), neglect, and nursing services. Edgewood Greenleaf Sioux Falls LLC was found not in compliance with the following requirement: S165.	S 000		
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 policy review, the provider failed to maintain the cleanliness of one of one kitchen as revealed by: *The wall behind the dishwasher in the kitchen	S 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 105	Continued From page 1 was unclean and in need of repair. *Improper hygiene and glove usage by one of one observed dietary aide (DA) (F). *The floor was dirty and sticky. *The cupboards were dirty and sticky. Findings include: 1. Observation and interview on 4/23/25 at 11:00 a.m. of the wall behind the dishwasher in the kitchen with the regional maintenance director G revealed: *On the south end of the wall by the serving window at counter height, an area approximately twelve inches wide and eight inches tall was damaged. *The paint was missing, exposing the paper of the sheetrock across the top four inches of the damage and the gypsum core of the sheetrock along the bottom four inches. *Along the south edge of the damage, approximately one inch of rusty metal corner bead was exposed. *Through the middle of the damage, the exposed paper had a black fuzzy mold-like substance that formed a strip that ranged from approximately two inches wide to half an inch wide and ran horizontally for approximately ten inches. *The wall behind the dish machine was covered with a white fiberglass panel approximately four feet by four feet. -That panel was covered with a yellow brown residue. *The wall below the counter of the dish machine had areas where the sheet rock had been cut and exposed the gypsum core of the sheet rock. *There was a moderate accumulation of debris splattered on the wall and along the floor under the dishwasher. *The regional maintenance director G confirmed those findings and agreed the wall should have	S 105	S 105 44:70:02:06 Food Service ED will be responsible for obtaining bids to repair wall. Completion of repair will be dependent on Contractor schedule.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 105	Continued From page 2 been repaired and cleaned. *The facility had been without a full-time maintenance person for about a month. *He was overseeing the maintenance of the facility until the full-time maintenanace position was filled. *He was not aware of the condition of the wall. 2. Observation and interview on 4/22/25 at 12:15 p.m. with DA F in the kitchen during the noon meal revealed: *There was a baking sheet containing chicken strips on top of the stove. *With gloved hands DA F took a spatula, removed three chicken strips from the baking sheet, and placed them on top of a cutting board on the counter. With her gloved hands she: -Took a knife and cut the chicken strips into smaller pieces. -Picked up the small pieces of chicken strips and laid them on top of a bowl of lettuce. -Placed the bowl of lettuce on the serving counter for the dining staff to serve to the residents. -Went to the refrigerator and opened it, and removed food items. -Touched multiple surfaces in the kitchen including opening drawers and cupboards. -Continued to remove chicken strips from the baking sheet, placed them on top of a cutting board, cut them up, and then with those same gloved hands, she picked up the cut-up chicken strips and placed them onto the bowl of lettuce. *She confirmed she had worn the same pair of gloves and had not changed them. 3. Observation on 4/22/25 from 12:02 p.m. through 12:12 p.m. in the kitchen revealed: *The walls were discolored, sticky, and dirty. *A cutting board contained slits, scratches, and scars, making it an uncleanable surface. *The cupboard doors had old food debris stuck	S 105	Re-education will be provided for all current dining staff on food safety, food handling, and preparation, serving and distribution procedures and sanitation requirements. In addition, hand washing hygiene and glove use policies will be reviewed with staff. All new dining staff will continue to be trained per SD new hire orientation checklist and Dining Service Manual by DSD. Audits on food storage, cleaning, glove and hair net use, handwashing will be completed by DSD/ED weekly for the next months. DSD to order new cutting boards.	June 7, 2025 June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 105	Continued From page 3 on them, and were dirty and sticky. *The dry food storage area had a large piece of linoleum missing from the floor in front of the refrigerator. *A large refrigerator with a dirty, sticky handle contained a plastic bag with meat that was not dated or had the contents identified. *The inside of several drawers contained food debris and were sticky to the touch. *The inside top of the microwave had dried food debris and was sticky to the touch. *The kitchen floor surrounding the cupboard baseboards was dirty, grimy, and visually soiled. Interview on 4/23/25 at 12:15 p.m. with dietary director C regarding hand washing, glove use, and cleanliness of the kitchen revealed: *DA F should have: -Removed her gloves and performed hand hygiene after touching other items in the kitchen. -Performed hand hygiene and put on new gloves prior to cutting up the chicken strips. -Used a tongs to pick up the cut-up chicken and place it on top of the bowl of lettuce. *They had a cleaning list that he had just revised. *There was no documented cleaning list provided indicating the staff had completed the cleaning list duties. Review of the provider's revised November 2022 Hand Hygiene policy revealed: *"Hand hygiene is the most effective way to prevent the spread of disease." *"Hand hygiene should be done: -Before and after caring for a resident. -Before or after handling food or medications. -After working with anything soiled. -Before putting on gloves. -After removing gloves."	S 105	DSD/ED to re-educate dietary staff on cleaning list. Weekly audit by DSD/ED on checklist and cleanliness of kitchen for the next 6 months. ED to provide documentation showing capital plan for new flooring as outlined in addition to new counter tops and cupboards per verbal tag.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	Continued From page 4	S 130		
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. 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, record review, interview, and policy review, the provider failed to maintain appropriate infection control practices for: *One of one observed resident's (5) treatment administration by one of one certified medication assistant (CMA) (D). *One of one observed resident's (6) personal care by one of one patient care attendant (PCA) (E). *One of one observed resident's (4) blood sugar check and medication administration by one of one CMA (D). Findings include: 1. Observation on 4/22/25 at 11:00 a.m. with CMA D revealed: *CMA D: -Removed a tube of ointment from the medication cart, and without performing hand hygiene, put on a pair of gloves. -Went to resident 5's room. *Resident 5 was sitting in her chair.	S 130	S 130 44:70:02:09 Infection Prevention and Control CSD to complete UMA competency checklist as a review for all Medication Aides. All new hires will receive this training as a part of their onboarding.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	Continued From page 5 *CMA D: -Placed the ointment and and a container of lotion on the table across from resident 5. -Sat on the floor and then pulled up resident 5's pant legs. -Took the ointment and squeezed a small amount onto her fingers and then rubbed the ointment onto the resident's leg. -With those same gloved hands she opened up the container of lotion, placed her gloved hands inside the container, and then rubbed the lotion on the resident's legs. -Removed her right glove and laid it on the floor next to her. -Took a glove from her pocket and without performing hand hygiene, put that glove on. -Applied an Ace elastic bandage wrap to both lower legs. -Removed her gloves in the room and did not perform hand hygiene. -Returned to the medication cart and placed the ointment in the bottom drawer. -Without performing hand hygiene, CMA D continued to set-up another resident's medications. 2. Observation on 4/22/25 at 11:15 a.m. in resident 6's room with PCA E revealed: *Resident 6 was sitting on the toilet and gave permission for the surveyor to observe her personal care. *PCA E: -Without performing hand hygiene put on a pair of gloves. -Assisted resident 6 to stand up. -Removed several wet wipes from a package and wiped resident 6's bottom area. -Pulled up resident 6's brief and slacks. -Flushed the toilet. -Removed her gloves.	S 130	Re-education for CMA D, PCA E and all staff on proper handwashing and glove use policies. Continue training to occur as outlined in our annual training calendar and documented through Relias Tracker.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	Continued From page 6 -Assisted resident 6 with washing her hands. -Assisted resident 6 with her walker out into the hallway. -Continued down the hallway without performing hand hygiene. 3. Observation on 4/22/25 at 11:35 a.m. with CMA D revealed: *Without performing hand hygiene, she: -Put on a pair of gloves. -Took a glucometer (device that measures blood sugar) from the medication cart. -Checked resident 4's blood sugar. -Discarded the bloody strip into the garbage. -Recorded the blood sugar reading on the electronic medication administration record. -Removed the Humalog KwikPen (insulin pen) from the medication cart. -Applied a new needle to the Humalog KwikPen and handed it to resident 4. --Resident 4 dialed the Humalog KwikPen and handed it back for her to verify the dosage was correct. *After resident 4 had completed the insulin injection she handed the insulin pen back to CMA D. *CMA D: -Removed the needle, discarded it into the Sharps container, and returned the Humalog KwikPen to the medication cart. -Continued to set-up the next resident's oral medications. Interview on 4/23/25 at 9:33 a.m. with registered nurse (RN)/clinical services director B regarding the above observations revealed: *She was assisting overseeing the facility because they did not have a clinical services director. *She agreed there were breaches in proper	S 130	DSD/ED to re-educate dietary staff on cleaning list. Weekly audit by DSD/ED on checklist and cleanliness of kitchen for the next 6 months. ED to provide documentation showing capital plan for new flooring as outlined in addition to new counter tops and cupboards per verbal tag. CSD to re-educate CMA D and all other Medication Aides on Blood Glucose monitoring checklist. Continued training will occur on annual UMA competency checklist.	June 7, 2025 June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	Continued From page 7	S 130	DSD/ED to re-educate dietary staff on cleaning list. June 7, 2025 Weekly audit by DSD/ED on checklist and cleanliness of kitchen for the next 6 months. ED to provide documentation showing capital plan for new flooring as outlined in addition to new counter tops and cupboards per verbal tag.	

infection control practices.
*Her expectations would have been for CMA D and PCA E to have washed their hands before and after each glove use.

Interview on 4/23/25 at 1:10 p.m. with CMA D regarding the above observations for resident's 4 and 5 revealed she should have performed hand hygiene before each time she put on gloves and after she removed her gloves.

Review of the provider's revised November 2022 Hand Hygiene policy revealed:
*"Hand hygiene is the most effective way to prevent the spread of disease."
*"Hand hygiene should be done:
-Before and after caring for a resident.
-Before or after handling food or medications.
-After working with anything soiled.
-Before putting on gloves.
-After removing gloves."

Review of the provider's January 2025 Gloves, Gowns, and Masks policy revealed:
*"Gloves must be worn whenever thee may be direct contact between an employee and contaminated objects or as instructed."
*Procedure:
-"1. Wash hands.
-2. Apply gloves to both hands.
-3. Remove contaminated materials.
-4. Place materials in proper receptacle.
-5. Remove gloves.
-6. Dispose used gloves in proper receptacle and rewash hands."

Review of the provider's revised November 2018 Measuring Blood Glucose Checklist revealed:
*Procedure:
-"10. Handwashing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	Continued From page 8 -11. Put on the gloves. -15. Discarded the lancet into the sharps container. -16. Removed and discarded the gloves. Decontaminated your hands." Review of the provider's revised August 2022 Non-Sterile Dressing Skill Competency revealed: *Purpose: "To be used for minor skin tears, abrasions, and other dressing changes that are not related to vascular wounds, pressure wounds, etc." *"Wash hands and put on gloves." *"Remove gloves and wash hands."	S 130	DSD/ED to re-educate dietary staff on cleaning list. Weekly audit by DSD/ED on checklist and cleanliness of kitchen for the next 6 months. ED to provide documentation showing capital plan for new flooring as outlined in addition to new counter tops and cupboards per verbal tag.	June 7, 2025
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI),observation, interview, care record review, and policy review, the provider failed to ensure a safe and secure environment for: *One of one closed record sampled resident (10) who had eloped (left the facility without staff knowledge) by not having completed visual resident checks and notifying the physician as directed in their elopement policy.	S 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 165	Continued From page 9 *One of one sampled resident (3) who was not provided a means to notify staff of needing assistance or of an emergency. Findings include: 1. Review of the provider's final SD DOH FRI report regarding the elopement of resident 10 revealed: *Date of event was 8/31/24. *Time of event was 4:00 a.m. *The door alarm had gone off. The staff had checked the door, searched the building and determined that all of the residents were accounted for. *A short time later, resident 10 then entered the building. *Resident 3's Saint Louis University Mental Status examination (SLUMS), (a cognitive impairment assessment), score was 0 because he was nonverbal, making it impossible to have completed the cognition examination. *"The staff member believed she saw the resident watching TV (as is common for him)." -The staff were educated to do visual presence of residents when doing checks on residents. *It was determined the "clinical staff followed the facility elopement policy." *"The facility will also require the resident [resident's] PCP [primary care provider] to determine that he is still appropriate for the assisted living level of care." Review of resident 10's closed care record revealed: *An admission date of 4/12/23. *Diagnosis of vascular dementia (damage to brain blood vessels that causes a decline in mental abilities). *The 2/14/25 evaluation of needs elopement/wander risk score was 9. A score of	S 165	S SSS CSD/ED to re-educate all staff on Prevention/Missing resident policy. Elopement drills to be completed quarterly as tracked by data recorded in company TELS system.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 165	Continued From page 10 10 or more indicated he was at risk of eloping. *The 9/5/24 SLUMS examination had not been scored or signed by a licensed nurse, which indicated it had not been completed. Review of the 8/31/24 Resident Note completed by [name of on-call nurse consulting support staff] at 4:50 a.m. regarding resident 10 revealed: *"Staff called to report that [the] east side exit alarm was sounding, and staff checked outside alarming door. Per staff no residents noted outside of alarming door and staff began safety check rounds for accountability of resident [residents]. Staff reporting 20 minutes [later] resident came in the front door and report that he fell outside trying to run away. Staff reporting resident denies pain, denies hitting his head, and able to move all extremities without difficulty. Resident currently back in room and resting in his bed." *"Interventions: Instructed staff to do safety checks on resident every 30 minutes. Writer updated executive director and will be calling staff with further instruction. Instructed staff to report any complaints or observations of pain or discomfort to an RN." *"Resident details: -Notification made to the family. -Notification made to community nurse and/or staff. Message left to call back." *There was no documentation that the physician had been notified. Interview on 4/23/25 at 9:05 a.m. with executive director (ED) A regarding resident 10's elopement revealed: *She had been notified by the on-call nurse company [name of company] regarding resident 10 having left the building. *The formerly employed CMA who was present at	S 165	SSSS SSS CSD/ED to re-educate all staff on Prevention/Missing resident policy. Elopement drills to be completed quarterly as tracked by data recorded in company TELS system.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 165	Continued From page 11 the time resident 10 eloped had described the event to ED A as follows: *Former CMA: -Heard the east exit door alarm sound. -Went to the door and had not seen anyone outside. -The other staff and she went to all the rooms to do a visual check. -When she looked into resident 10's room she thought she had seen his head protruding from the back of his recliner. -Continued to check for the rest of the residents and thought everyone was accounted for. *A while later, resident 10 had come to the front door. *They did not know at that time if he had left the facility grounds or if he had his walker with him. *Around 5:00 a.m. the on-call nursing company had called the facility's on-call registered nurse (RN) H. He had not answered his phone. *ED A had texted RN H at 8:59 a.m. to instruct RN H to have his family take resident 10 to see his physician. -She also wanted to have a urine analysis completed for him. -When she returned to work five days later, she requested a urine analysis be done and "they didn't do it." -She wasn't sure if the family had refused to take resident 10 in to be seen by the physician. *There was no documentation the family had refused to take resident 10 to see the physician. *There was no documentation the physician had been contacted regarding the elopement. *She stated they had put 30-minute safety checks in place, but there was no documentation to support that had happened at the time of the elopement. *Agreed they had not followed their elopement policy regarding doing a visual check on each	S 165	SSS CSD/ED to re-educate all staff on Prevention/Missing resident policy. Elopement drills to be completed quarterly as tracked by data recorded in company TELS system.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 165	Continued From page 12 resident and had not notified the physician. Interview on 4/23/25 at 10:03 a.m. with RN/clinical services director B regarding resident 10's elopement revealed: *Her expectations would have been for the formerly employed CMA to have "put eyes" on every resident in their rooms, especially since it had occurred in the early morning. *The physician should have been contacted. *There should have been documentation regarding if he had been seen by the physician or if the family had refused to have him seen by the physician. *Interventions of having him checked every 30-minutes should have been documented. *She was able to find every 30-minute checks starting on 9/3/24, which was three days after the elopement. -The computer program should have been able to show if every 30-minute elopement checks had been done. -"The computer system RTask was hard to pull things from." *She was unable to find any documentation the physician had been notified regarding resident 10's elopement or that he had been seen by a physician. Review of the provider's January 2025 Elopement risk Prevention/Missing Resident policy revealed: *Policy guidelines: -"To promote resident safety and protect the rights and dignity of the residents." -"Maintains a process to assess all residents for risk for elopement." *Intervention: "2. d.: Staff conduct a thorough search to locate the resident." *"When a resident is found: The attending physician is notified of the resident's status."	S 165	CSD/ED to re-educate all staff on Prevention/Missing resident policy. Elopement drills to be completed quarterly as tracked by data recorded in company TELS system.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 165	Continued From page 13 2. Observation and interview on 4/22/25 at 1:15 p.m. with resident 3 inside her apartment revealed: *She had been at the facility for a while. *She thought she had been admitted to the facility around 11/5/24. *They had given her the watch pendant (device to notify staff of needing assistance) upon admission. *The watch pendant had not worked upon admission. *They sent off for another watch pendant but had not received it for a few weeks. *She did not have any other way to contact staff if she would have needed assistance. *"They must have figured I was independent and did not need any help." *She had a watch pendant on which she was able to describe and show how she would use it if she needed any help. *She gave permission for the surveyor to bring the non-working watch pendant issue up to administration. Interview on 4/23/25 at 1:30 p.m. with ED A regarding resident 3 and her watch pendant revealed: *Resident 3: -Was admitted to the facility on 3/24/25. -Had periods of confusion. *She had been provided a watch pendant on admission. -The watch pendant had not worked. *The facility had to order a new watch pendant. *There were no other watch pendants in the building at that time. *A new watch pendant arrived on 4/15/25 and was placed on resident 3's wrist at that time. *The watch pendant was used for the residents to	S 165	S 165 44:70:02:17 Occupant Protection ED/MD to ensure that there are always to extra pendants available and ready for use or to replace damaged non-working pendants. MD to audit inventory monthly/ongoing.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 165	Continued From page 14 alert staff if they needed assistance with activities of daily living, emergencies, medications, falls, or when they had felt dizzy. *There were no interventions in place for resident 3 to notify staff for a time resident 3 had gone without the watch pendant. *They did not have a policy for a watch pendant. *Agreed resident 3 would not have had any way to contact staff if she needed assistance or if she was having an emergency.	S 165		
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: Based on observation and interview the provider failed to maintain fire-rated doors in good repair for: *Three randomly observed twenty-minute fire-rated doors to storage rooms that were coming apart and would not close with the self-latching feature (by northwest activity room, between rooms 101 and 102, and between rooms 202 and 203). *One randomly observed twenty-minute fire-rated storage room door that would not latch into the frame (between rooms 111 and 112).	S 201	SSS CSD/ED to re-educate all staff on Prevention/Missing resident policy. Elopement drills to be completed quarterly as tracked by data recorded in company TELS system.	June 7, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 201	Continued From page 15 *One of one ninety-minute fire-rated doors to the mechanical room that was coming apart and would not close with the self-closing feature. Findings include: 1. Observation throughout the facility on 4/23/25 from 9:00 a.m. through 1:30 p.m. revealed: *The twenty-minute fire-rated doors to the storage rooms located by the northwest activity room, between rooms 101 and 102, and between rooms 202 and 203 had all come apart by the top hinge. -Those doors had lost their structural integrity and were sagging, causing them to drag on the floor. -Those doors had to be physically lifted to open and close. * The twenty-minute fire-rated storage room door between rooms 111 and 112 would not latch into the frame. *The ninety-minute fire-rated door to the mechanical room was coming apart by the top hinge. -That door had lost its structural integrity and was sagging, causing it to drag on the floor. -It would not close with the self-closing feature. 2. Interview on 4/23/25 at 1:30 p.m. with regional maintenance director G confirmed those findings and revealed: *The facility had been without a full-time maintenance person for about a month. *He was overseeing the maintenance of the facility until the full-time maintenanace position was filled. *He was not aware of the condition of the doors. *He agreed those doors should have been repaired or replaced.	S 201	S 201 44:70:03:02 General Fire Safety MD to have all tagged fire doors ordered for replacement.	June 7, 2025
S 654	44:70:07:06 Drug Disposal	S 654		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 654	Continued From page 16 Any medication held for disposal must be physically separated from the medications being used in the facility and locked with access limited in an area with a system to reconcile, audit, or monitor them to prevent diversion. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure one of one sampled resident's (4) controlled medications (medications with risk for abuse and addiction) were secured and accounted for in one of two medications carts (CMA2). Findings include: 1. Observation and interview on 4/22/25 at 11:35 a.m. with registered nurse (RN)/clinical services director B and certified medication aide (CMA) D regarding controlled medication storage revealed: *The controlled medications were kept on each medication cart. *Inside the drawer of the CMA2 medication cart was a locked drawer. -Inside that drawer were several residents' controlled medications. *The controlled medications were to be counted each shift by two staff. *The controlled medication count was then to be recorded on the electronic medication administration record. *The controlled medication count for resident 4 revealed: -A medication bubble pack labeled clonazepam (a controlled sedative) 0.5 milligrams (mg). --The medication slots numbered #15 and #16 had the clonazepam tablets taped back into the package.	S 654		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47882	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SIOUX FALLS LLC	3409 EAST 5TH STREET SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 654	Continued From page 17 Interview at that time regarding the above medication bubble package with CMA D and RN/clinical services director B revealed: *CMA D stated "One staff member's finger nail caught the backside of the medication package." *RN/clinical services director B's expectations would have been those medications should not have been taped back into the bubble package. Review of the provider's January 2025 Medication Administration policy revealed: *"Purpose: To ensure optimal and safe medication handling, storage and administration for all residents." *"Policy: All medications will be handled, stored, and administered based on the state and Community requirements." *"Practice: -O. All medications that are refused or discarded by the resident will be documented in the electronic medical record and destroyed appropriately."	S 654	S 654 44:70:07:06 Drug Disposal CSD/LPN to re-educate all Medication Aides on Medication Administration policy. All new staff trained with onboarding process. CSD/LPN to do audits at med exchange monthly for the next 6 months.	June 7, 2025