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
	67663	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH VERMILLION DAKOTA GARDENS	126 S PLUM ST VERMILLION, SD 57069

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S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted 9/30/25 through 10/2/25. Sanford Health Vermillion Dakota Gardens was found not in compliance with the following requirements: S030, S201, S331, and S685.	S 000	1. Employee A/Director of Nursing completed a late facility incident/SAFE report 10/16/25 on Resident 1's elopement from May 2025 to document the details of the incident and follow up since staff had not completed one at the time of the incident. Employee B/ LPN educated Resident 1 on 10/16/25 to use the sign out sheet when leaving the building so staff know where resident is at all times. Employee C/MDS Coordinator updated Resident 1's service plan on 10/17/25 to include education was given to resident on signing out when leaving the building and that he uses his personal car, is allowed to leave the facility and does not require supervision. The Improvement Advisor revised the Elopement policy to add all elopements will be reported to the SD Department of Health. Employee C also created Read and Sign education on 10/14/25 for all staff which included the definition of elopement, the elopement policy, required reports to the SD Department of Health and reminder that all residents need to sign out when leaving the building. If staff see residents leaving without signing out, the staff will inquire where resident is going, when they will return and document on the sign out sheet. PRN staff will sign off on the education before their next shift.	
S 030	44:70:01:07 Reports To The Department Each facility shall report the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event.	S 030	2. All residents will be educated at Tenant Council meeting on 10/29/25 by the IDT on signing out when leaving the facility. Employee C wrote an article for the November family newsletter which will be sent out to all family contacts by 10/31/25 asking family members to let staff know and sign out residents when taking them out of the facility. Employee A put signs on the inside of exit doors that say, "Please sign out before you leave" to remind residents and families to sign out and added a sign out sheet by the south exit door to the parking lot on 10/16/25. Employee C created an admission checklist on 10/8/25 which she, Employee B and social worker will use with all new admits to ensure all necessary tasks are completed. It includes reviewing the sign-out process with new admissions and their families. 3. Employee C or designee will audit the sign out sheets and ask staff if any residents left without signing out or eloped. If there was an elopement reported verbally or by incident report, she will check to ensure a report was made to the Department of Health. The audit will be done twice per week for a month, once a week for a month, every other week for a month, and monthly for three months. She will also audit the training of all new assisted living staff to ensure they are educated on the elopement definition and policy monthly for 6 months. Employee C or designee will report these audit results at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Veronica Schmidt — TITLE: CEO — (X6) DATE: 10/17/25

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S 030	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review the provider failed to report one of one sampled resident (1) who eloped (left the facility without staff knowledge) to the South Dakota Department of Health (SD DOH). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *On 5/20/25 at 7:00 p.m. the facility had been informed by a local citizen resident 1 was found at a cemetery. *Resident 1 told the citizen he "Snuck out" of the facility to go to the cemetery. *Resident 1 had injured his right lower leg while out of the facility. Interview on 10/2/25 at 8:00 a.m. with resident assistant/medication aide (RA/MA) D regarding resident 1's 5/20/25 elopement revealed: *He had last seen resident 1 that day between 5:45-6:00 p.m. *Resident 1 had not informed staff he was leaving the facility. *Resident 1 returned to the facility around 7:00 p.m. RA/MA D noticed resident 1 injured his right leg and informed the nurse. Interview on 10/2/25 at 8:30 a.m. with director of nursing A regarding reporting resident 1's elopement to the SD DOH revealed: *She contacted their quality and risk department for guidance. *They informed her she did not need to report resident 1's elopement to the SD DOH because he was able to leave the facility when he wanted to.	S 030		

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S 030	Continued From page 2 *She was not aware of the assisted living centers rules regarding reportable incidents which included a missing resident/resident elopement. Review of the provider's September 2025 Security Alert: Missing Person-Elopement revealed: *"Elopement will be defined as any resident leaving the grounds of the facilities without the knowledge of staff, or any patient/resident unable to be located on the grounds/facilities."	S 030		
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, interview, and record review the provider failed to maintain battery back-up exit signs as required. Findings include: 1. Observation on 10/1/25 at 11:29 a.m. revealed the provider had exit signs with an internal battery-operated automatic back-up. Exit signs with an internal battery-operated automatic back-up require monthly 30-second tests and 90-minute annual tests. Interview with the maintenance supervisor at that same time	S 201	1. The Maintenance Supervisor created a checklist/log on 10/15/25 of all the battery back-up powered Exit signs at the Assisted Living facility so Maintenance/Plant Operations staff can document when these are checked monthly for 30 seconds and annually for 90 minutes. The ones at the Assisted Living were tested on 10/16/25 for 30 seconds and documented on the log by Maintenance staff. They will also be tested for 90 minutes and documented on the log by Maintenance staff before 11/16/25. 2. The Maintenance Supervisor educated all Maintenance/PO staff via read and sign education on 10/16/25 that the battery back-up powered Exit signs in the facility need to be checked monthly for 30 seconds and annually for 90 minutes and documented on the log. They put this checklist/log with all their other monthly and annual Preventative Maintenance tasks that they do. 3. The Maintenance Supervisor or designee will audit the log monthly to ensure all monthly and annual checks are being done timely on all the battery back-up powered Exit signs at the facility. He will sign off on the log each month after his review noting any discrepancies for a period of 6 months and turn into the Improvement Advisor. The Improvement Advisor or designee will report on the findings of the audit at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

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S 201	Continued From page 3 confirmed that condition. He stated the maintenance staff did not have a task and have not been performing those required tests on those devices. Record review later that same day revealed the provider did not have documentation for performing those required tests.	S 201		
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or	S 331	1. On 10/14/25, Employee C reviewed all residents at the facility to determine if there were any other residents who did not get their TB screening test and found 5 additional residents. On 10/14/25, Employee A and Employee C gave Residents 1, 3, 4, 5 and the 5 other residents their first step TB screening test. These were read by Employee B on 10/16/25. They were all negative. The second step TB screening test will be give to 7 of those residents on 10/21/25 by Employee C and Employee A as two of them came from other facilities with documentation of TB test per our policy then only need 1 step TB test. These 7 residents' second step TB test will be read by Employee B on 10/23/25. 2. Employee C created an admission checklist on 10/8/25 which includes giving new residents the TB screening tests within 21 days of admission to the facility. Two-step TB test will be given unless resident comes from another facility and has documentation of testing already completed; then one TB screening test will be done within 21 days of admission. Employee C educated all licensed nursing staff on this process via read and sign education that was put out on 10/14/25. 3. Employee C or designee will audit all new admits to ensure the TB tests are completed and read timely each week for a month, then bi-weekly for a month, and monthly for four months. Employee C or designee will report the results of these audits at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

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S 331	Continued From page 4 resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview the provider failed to ensure four of four sampled residents (1, 3, 4, and 5) had a two-step tuberculosis (TB) Mantoux (a screening tool to determine if a person has been infected with the bacteria that causes TB) skin test completed within twenty-one days of admission to the facility. Findings include: 1. Review of resident 5's closed electronic medical record (EMR) revealed: *She was admitted on 11/20/24 and discharged on 8/4/25. *No documentation indicated her TB test was completed when she admitted to the facility. 2. Review of resident 1's EMR revealed he was admitted on 1/21/25 no documentation indicated of his TB test had been completed. 3. Review of resident 4's EMR revealed she was admitted on 3/17/25 no documentation indicated her TB test had been completed. 4. Review of resident 3's EMR revealed she was admitted on 7/24/25 no documentation indicated her TB test had been completed. Interview on 10/1/25 at 9:30 a.m. with licensed	S 331		

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S 331	Continued From page 5 practical nurse (LPN) B regarding the completion of residents TB testing revealed: *She was not aware TB testing was not completed on the above residents. *She was aware TB testing needed to be completed on new residents unless they had documentation the testing was completed within twelve months of their admission. Interview on 10/2/25 at 7:40 a.m. with director of nursing (DON) A and Minimum Data Set (MDS) coordinator C regarding residents TB testing revealed: *They expected residents to have TB testing completed after admission to the facility. *They were not aware the above residents did not have TB tests completed.	S 331		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration.	S 685		

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S 685	Continued From page 6 This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure two of two sampled residents (2 and 3) who self-administered injectable medications were assessed for the ability to safely self-administer those medications. Findings include: 1. Interview on 9/30/25 at 8:20 a.m. with licensed practical nurse (LPN) B revealed resident 2 and resident 3 were able to self-administer medications. 2. Interview on 9/30/25 at 11:00 a.m. with resident 2 regarding self-administering medications revealed: *She self-administered her Trulicity an injectable medication used to treat type 2 diabetes (a condition that disrupts how the body regulates blood sugar) every Friday. *She stored that medication in her apartment refrigerator. 3. Review of resident 2's electronic medical record (EMR) revealed: *An 8/29/24 physician's order to self-administer her Trulicity. *No documentation indicated she was assessed for her ability to safely self-administer that medication. 4. Record review of resident 3's EMR revealed: *A 7/23/25 physician's order to self-administer her Lantus insulin (a long-acting insulin used to manage blood sugar levels in adults and some children with diabetes). *No documentation indicated she was assessed	S 685	1. Employee B completed the initial assessments for Residents 2 and 3 to ensure they were safe to self-administer their medications on 10/1/25. Employee C completed a review on 10/1/25 of all residents' records to determine if there were any other residents who self-administer medications that needed assessments completed. She identified one other resident with a 7-day cream and 2 other residents with self-administered medications that needed initial assessments completed. Employee B completed these 3 additional residents' initial assessments to ensure they could safely self-administer their medications on 10/1/25 as well. 2. Employee C placed an order in the EMR for each of the 4 residents who are self-administering medications to have quarterly assessments done for evaluation to continue to safely self-administer medications. The resident with the 7 day cream would not need the quarterly assessment so that one was not put in. Employee C created an admission checklist on 10/8/25 and included completing an initial assessment of the resident if he/she wants to self-administer any medications. If a resident gets a new medication order to self administer a medication after admission, Employee B will put in an order to complete the initial and quarterly assessments and conduct the initial assessment. prior to resident self-administering. Employee C provided Employee B with a checklist/log of all current residents who self-administer medications on 10/17/25 so she can update the list as orders change, new residents are admitted who self-administer medications or residents discharge. There are columns for documenting when their initial and quarterly assessments were completed. Employee C educated all licensed nursing staff that if residents are going to self-administer medications, they need to have an initial and quarterly assessments completed prior to self administering via read and sign education that she put out for staff on 10/14/25. 3. Employee C or designee will audit the log once a week for a month, bi-weekly for a month and monthly for four months and report the results at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

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S 685	Continued From page 7 for her ability to safely self-administer her Lantus insulin. 5. Interview on 10/2/25 at 9:30 a.m. with LPN B regarding resident 2 and resident 3's evaluation to self-administer medication revealed: *She was not aware that residents needed to be assessed for the ability to safely self-administer medications. *She thought the physician's order was sufficient. 6. Interview on 10/2/25 at 2:10 p.m. with director of nursing (DON) A and Minimum Data Set (MDS) coordinator C regarding assessing residents for safe self-administration of medication revealed: *They were aware residents who wanted to self-administer medications should have been assessed for their ability to safely self-administer medications. *They were not aware that residents 2 and 3 were not assessed for safe self-administration of medications. Review of the provider's August 2025 Self-Administration of Medications-Assisted Living revealed: *"ALC residents who will be self-administering medications will be assessed by a nurse prior to self-administering medication and re-assessed for continued appropriateness of self-administering per state regulations." *"The EMR Self-Administration of Medications-AL will be completed by the nurse according to state regulations and board of nursing rules."	S 685		