

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10762	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER KIMBALL RETIREMENT LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 313 S. WATER STREET KIMBALL, SD 57355		
(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 7/21/26 through 7/23/26. Kimball Retirement Living was found not in compliance with the following requirements: S201, S337, S405, S685, and S800.	S 000		
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 record review and interview, the provider failed to conduct two fire drills during sleeping hours from July 1, 2025 to July 21, 2026. Findings include: 1. Record review and interview on 7/21/26 at 4:30 p.m. of the fire drills with administrator A revealed in August, September, and December of 2025 there were no fire drills recorded. She had retrained the staff in January 2026. They had conducted fire drills every month since January 2026. None of those fire drills in the last year were done during sleeping hours and woke the	S 201	The facility will conduct fire drills in accordance with South Dakota Administrative Rule . The facility will ensure that two fire drills during sleeping hours will be included into the monthly fire drills done yearly. Drills during sleeping will be done at varying times, staff education completed to the appropriate policy and procedure for safely responding to a fire emergency while residents are sleeping. The administrator or designee will be responsible for scheduling all required fire drills. Documentation will include date and time of the drill, shift, staff participating, evacuation time, any problems identified and corrective action taken when needed. Facility staff educated to fire drill requirements, including the requirement of fire drills during sleeping hours. Staff instructed on their responsibilities during fire emergencies and the importance of maintaining resident resident safety and meeting required evacuation times. The administrator or designee will review the fire drill documentation monthly for the next 12 months to ensure all drills have been completed as required and appropriately documented. The administrator will maintain oversight of the schedule and documentation to ensure continued compliance. This will be discussed at monthly QA meetings, any issues will be addressed at that time.	9/6/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Shelly Fredericksen**

TITLE **Manager**

(X6) DATE **8/21/2026**

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S 201	Continued From page 1 residents. She agreed there should have been two fire drills done during sleeping hours during the last year.	S 201		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to document an annual smoking assessment for one of three sampled residents (2). Findings include: 1. Review of resident 2's medical record revealed he had his annual review and service plan updated on 3/10/26. His last smoking assessment was completed on 6/9/25. 2. Interview on 7/21/26 at 3:30 p.m. with registered nurse (RN) B revealed she had sat and watched resident 2 smoke but forgot to document that in the smoking assessment. 3. Review of the provider's undated Resident Tobacco Use policy revealed: "Purpose: To ensure safe tobacco use for all residents. 3. All residents tobacco use will continue to be re-assessed on an annual basis and upon any significant change of health status."	S 337	Policies and procedures were reviewed and adequate to meet state compliance. The previous RN was terminated and a new RN was hired and trained to the facility Smoking Assessment Policy and Procedure. The smoking assessment on resident #2 was complete on 7/22/26 The resident Smoking Assessments will continue to be completed on admission, quarterly, annually and with any significant change. All services needed for a resident will be listed in the Care Plan and updated as needed to meet the residents needs. The facility manager or designee will audit the smoking assessments and resident care plans on a monthly basis over the next 3 months followed by quarterly reviews for the following 9 months. This will be discussed during monthly QA meetings, any issues will be discussed at that time.	9/6/26

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S 405	Continued From page 2	S 405		
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to update the service plan to reflect the current needs for two of three sampled residents (1 and 2). Findings include: 1. Review of resident 1's medical record revealed that on 4/7/26 RN B wrote a progress note that indicated "Completed yearly MMSE [Mini Mental State Examination] and EVAL [resident needs evaluation tool] started discussion of care plan items and determined [we] would finish care plan review next week as she [resident 1] was exhausted from dialysis. Noted resident had some congestion and runny nose she reported that she was already feeling better from the other day and just wanted to monitor how things go and that she would have son [name] take her to the doctor if she got worse" On 4/14/26 RN B wrote a progress note that indicated "Resident was admitted to [hospital name] after dialysis on Friday 4/10/26 for SOB [shortness of breath], DX [diagnosis]: RSV [Respiratory Syncytial Virus]. Discharged today 4/14/26 due to needing dialysis treatment, new	S 405	Policies and Procedures were reviewed and were shown to be adequate in meeting state compliance. Previous RN was terminated and new RN was hired and trained to our Care Plan Policies and Procedures. All Care Plans will be started upon admission and reviewed/updated anually and as needed to meet residents needs. Any resident smoking or needing oxygen will have it listed on thier Care Plan. Care plan of resident #1 and resident #2 were updated on 7/30/26 by new facility RN following the faciltiy survey. Manager and RN or designee will monitor Care Plans monthly for the next 12 months. Progress notes will be updated to any signifiacnt activities of each resident as they occur. RN will follow up any medical or pharmacuetical needs. Care plans will be updated to any changes. Both the care plans and progress notes will be audited weekly for the next 3 months them monthly for the follwing 9 months. These will be addressed at monthly QA meeting, any issues will be discussed at this time.	9/6/26

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S 405	Continued From page 3 orders for Cefdinir [antibiotic] daily x [for] 4 more days, was not administered today to receive after dialysis treatment, also new orders for Benzonatate capsule for cough, and supplemental O2 [oxygen] continuous 1L [liter]. [Name of home health provider] to deliver oxygen concentrators and new style walker this evening, resident was provided with an old style portable [oxygen concentrator] due to dialysis treatment time longer than what oxygen tanks can provide, may apply for a portable [concentrator] if at 30 day follow up its determined resident will continue to need continuous supp [supplemental] O2." On 6/2/26 RN B wrote a progress note that indicated "Resident saw PCM [principal care management] last week, decrease supp O2 use to 1L with activity and none at rest. New order for Lomotil [to treat diarrhea] 2 tabs QID PRN [four times a day as needed] and Lactase [supplement to treat lactose intolerance] 3000 units 1tab [tablet] before meals daily." Resident 1's 2/19/25 service plan indicated it was more than a year old. There was no mention of oxygen use in the service plan. Resident 1's medication administration record (MAR) indicated that the physician's order for oxygen was listed as continuous 1L and was not updated to the new order "1L with activity ." 2. Phone interview on 7/21/26 at 3:35 p.m. with RN B revealed she had started resident 1's annual review on 4/7/26. The resident went to the hospital on 4/10/26. When resident 1 returned to the facility, they were not sure how long the oxygen order would be in effect. RN B was waiting for the issue with the oxygen order to be resolved, and then she was going to complete	S 405		

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S 405	Continued From page 4 resident 1's service plan. She had forgotten to complete the service plan. 3. Interview on 7/21/26 at 3:40 p.m. with administrator A revealed she would have expected the service plan to be updated after the oxygen was ordered even if it was temporary. 4. Review of resident 2's medical record revealed he was a smoker. His last smoking assessment was completed on 6/9/25. He was unsupervised with smoking, kept his own lighter, and the facility stored his cigarettes. He gets two cigarettes in the morning, three at 2:00 p.m., and one at 7:00 p.m. He rolled his own cigarettes. Resident 2's 3/10/26 service plan did not have a category for smoking. Smoking was not addressed on the service plan. 5. Interview on 7/22/26 at 2:00 p.m. with administrator A revealed she expected resident 2's smoking to be addressed on the service plan. It was a daily activity for him. If resident 2 was left unregulated, he would smoke more cigarettes in a day. 6. Review of the providers' update Care Plan Policy and Procedure revealed "Basic responsibility: Registered Nurse. Purpose: Care plans will be developed by an interdisciplinary team with participation of the resident, family, and/or representative (when available). Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care. Care plans may also	S 405		

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S 405	Continued From page 5 include current physician's orders, CG [care giver] input from QUICKMAR charting, MAR [medication administration record] and TAR [treatment administration record], Dietician recommendations and PT/OT/ST [physical therapy, occupational therapy, and speech therapy] if resident is receiving treatment. General instructions: 1. Upon admission, resident will be assessed by the Licensed Nurse and a baseline care plan will be developed with information gathered from the resident and resident's family. 2. Physicians review medications with annual or significant change office visits. Pharmacy reviews medications monthly and PRN [as needed] and makes recommendations. Staff continually monitors for adverse reactions or significant changes in resident conditions. Physician is notified as needed. 3. Care plans will be reviewed quarterly, annually, and with any significant change in resident condition. 4. Short term changes to the care plan will be added as necessary to the resident's Short Term Care Plan. 5. Care plans are written by exception from Resident Centered Care Plan Facility Standards and Short Term Care Plans. They include outcomes and identify interventions that are specific to the individual resident. Target dates are through next review period unless otherwise specified."	S 405		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued	S 685	Policies and Procedures were reviewd and shown to be adequate in meeting state compliance. New RN was hired and trained to the Policies and Procedures of the residents self-administration. Assessments of residents 1 and 3 were completed by new facility RN. Both Care Plans were updated to reflect current assessments.	9/6/26

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S 685	Continued From page 6 appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to complete a quarterly assessment for the self-administration of medication for two of three sampled residents (1 and 3). Findings include: 1. Review of resident 1's medical record revealed she was approved for self-administration on 4/18/23 for an albuterol inhaler. On 1/3/24 Pepto Bismol chewable tablet (for indigestion) and Lactaid (dietary supplement) were added to the self-administration list. Her last quarterly self-administration assessment was done on 3/24/26. On 4/21/26 registered nurse (RN) B wrote a progress note that indicated "Resident had follow up in clinic on 4/20/26 DC'd [discontinued use] Hydralazine [for high blood pressure], Citrucel Diphenoxylate/atropine [for diarrhea], Pepto Bismol chewable tablets and MiraLAX [for	S 685	The facility manager and RN or designee will audit Self Administration Assessments on a monthly basis over the next 3 months and then every 3 months over the following 9 months to ensure all required quarterly, yearly and significant change assessments are completed and updated in accordance to the residents needs. This will be addressed at monthly QA meetings, any issues will be discussed at this time.	

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S 685	Continued From page 7 constipation]. Follow up in one month regarding oxygen and activity." 2. Phone interview on 7/21/26 at 4:20 p.m. with RN B revealed she should have assessed resident 1's ability to self-administer medications in June. The self-administration assessments were to be done every three months. 3. Review of resident 3's medical record revealed she received a physician's order for cough drops and to keep them at her bedside on 10/20/25. She signed a self-administration agreement on 10/27/25. There were no documented self-administration assessments from that date. 4. Interview on 7/22/26 at 2:10 p.m. with administrator A revealed resident 3 should have had an self-administration assessment when she signed the self-administration agreement on 10/27/25 and every three months from that date. 5. Review of the provider's self-administration policy revealed "Staff RN [registered nurse] will monitor residents' ability to maintain self-administration ability through an assessment process done quarterly, yearly, and on any significant changes."	S 685		
S 800	44:70:09:04 Notification When Resident's Condition Change A facility shall immediately inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and, if known, notify the resident's legal representative or interested family member when any of the following occurs:	S 800		

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S 800	Continued From page 8 (1) An accident involving the resident that results in injury or has the potential for requiring intervention by a physician, physician assistant, or nurse practitioner; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, policy review, and medication label review, the provider failed to notify the medical provider of a change in condition for one of three sampled residents (2). Findings include: 1. Review of resident 2's medical record revealed that on 1/13/26, registered nurse (RN) B wrote a progress note that indicated "January Pharmacy recommendation consider reduction in Escitalopram [for anxiety] 20 mg [milligrams] PO [by mouth] Q AM [once daily in the morning]. Faxed to [medical provider's name] who manages resident's mental health medications. Return fax disagree, leave medication as is, due to constant high anxiety. No medication change" From 1/13/26 to 4/14/26, there were are no new physician's orders for medication changes and the resident's condition seemed stable, as the resident expressed no changes or concerns. On 4/14/26 RN B indicated in a progress note, "Resident received COVID vaccine on 4/8/26. No adverse reactions reported." On 4/27/26 medication aide C indicated in a	S 800	Policies and Procedures were reviewed and shown to meet state compliance. Conversation took place with previous facility RN in regard to her non compliance in following the facility policy and procedures. RN agreed to non compliance issues and was terminated. New RN was hired and trained to the policies and procedures of reporting a change in a residents condition. RN was was updated to survey and facility expectaions. RN or designee will report any changes in a residents condition to residents PCP and designated family member. Progress notes will be entered to reflect the reporting of any changes in conditions. Staff have been reducated to any instances of self harm will be reported to facility RN immediately . Appropriate charting in regard to the situation must be completed by staff witnessing the event, followed up by the facility RN and reported to resident physician. Manager or designee will monitor charting on any residents change in condition to ensure proper documentation isin place. Audits will be done monthly for 3 months, follwed by quaterly the following 9 months.	9/6/26

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S 800	Continued From page 9 progress note , "Resident had an appt [appointment] with psychologist today. She increase[d] residents [resident's] Ingrezza [for uncontrollable face and body movements] from 40 to 80 mg. Reviewed and approved order." On 4/28/26 RN B indicated in a progress note, "resident was seen for routine medication review with [provider's last name]. New order to increase Ingrezza to 80 mg and continue all other medications." On 5/12/26 RN B indicated in a progress note, "Another resident reported that the resident [resident 2] had stated having suicidal thoughts over the last week as he had a couple of difficult days in a row. Visited with resident again, he was in good spirits smiling enjoying conversation. He reported no thoughts of harming himself but that he does have those thoughts he reports them to his counselor that he sees every two weeks. Discussed resident's Lorazepam [for anxiety] with him, as he has had an increase in difficulty in the mornings functioning at breakfast. He reports that he does not always take the lorazepam in the morning when it is brought into him because he is scared of running out of available Lorazepam to him during the day. Resident has had concerns and reaction in the past. Discussed how the scheduled Lorazepam helps him stay ahead of his symptoms in which often he does not require his PRN's [as needed medication] after getting on a good controlled schedule. Resident reported understanding and agreed it is easier to manage the anxiety symptoms when he stays ahead of them and will ensure he takes his pill when it is brought to him instead of holding onto it or waiting to take it." On 6/9/26 RN B indicated in a progress note,	S 800		

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S 800	Continued From page 10 "Invega [antipsychotic] injection completed today during nursing visit, sent reorder to pharmacy for 7/7/26 administration to be sent out when they can. Resident reports doing better this afternoon but he had a difficult morning. Resident reports no pain and generally sleeping well however over the last week when visiting with another staff member he reports that he had not been sleeping well and reported negative thoughts about general wanting to fight. Previously resident's caffeine intake was restricted specifically with coffee. Currently has free access to coffee, his sister has reported concerns and is planning to get him caffeine free tea and pop to try to combat the caffeine intake and is considering going with him for psych appointment in Mitchell." On 6/29/26 RN B indicated in a progress note, "Resident reported that he was suicidal on 6/28/26 in the AM [a.m.] after getting up for the day, however he did not want to hurt himself. Staff had [the] resident sit in the common area until he started feeling better after taking his AM medications and his anxiety symptoms decreased. Resident was having a hard time sitting still earlier today but was able to sit down and have a conversation this afternoon. He can not recall what he was feeling yesterday just that the word suicide was going through his head reports he's doing better today and does not want to hurt himself. Resident reports no other concerns." 2. Phone interview on 7/22/26 at 3:30 p.m. with the registered nurse who works for the medical provider who managed resident 2's mental health medications revealed there was no communication from the assisted living regarding resident 2's suicidal thoughts.	S 800			

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S 800	Continued From page 11 3. Interview on 7/22/26 at 3:45 p.m. with administrator A revealed she expected RN B to notify the medical provider after the documentation on 5/12/26 indicated suicidal thoughts. 4. Review of the provider's undated untitled policy regarding self-harm ideations revealed "4. Any thoughts of suicidal ideation or self-harm must be reported to the facility RN immediately. Appropriate charting in regard to the situation must be completed by staff witnessing the event, followed up by the facility RN and reported to resident physician." 5. Review of the online "important safety information" for Ingrezza revealed, "Ingrezza or Ingrezza sprinkle can cause serious side effects in people with Huntington's disease, including: depression, suicidal thoughts, or suicidal actions. Tell your healthcare provider before you start taking Ingrezza or Ingrezza sprinkle if you have Huntington's disease and are depressed (have untreated depression that is not well controlled by medicine) or have suicidal thoughts. Pay close attention to any changes, especially sudden changes in mood, behaviors, thoughts, or feelings. This is especially important when Ingrezza or Ingrezza sprinkle is started and when the dose is changed. Call your healthcare provider right away if you become depressed, have unusual changes in mood or behavior, or have thoughts of hurting yourself."	S 800		