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
	41969	A. BUILDING: _____ B. WING _____	10/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NANO NAGLE VILLAGE	1020 N JAY ST ABERDEEN, SD 57401

(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 10/20/26 through 10/21/26. Nano Nagle Village was found not in compliance with the following requirements: S337.	S 000		
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: A. Based on observation, interview, manufacturer's instructions for use review, and policy review, the provider failed to ensure the staff administered residents' medications according to the provider's policy and according to manufacturer's instructions for use by one of one registered nurse (RN) (B) who prepared morning medications in the dining room before the residents were available for the medications to be administered, and did not prime one of three sampled residents' (5) insulin pen before she administered their medication. Findings include: 1. Observation on 10/21/26 at 7:35 a.m. in the dining room revealed approximately twenty residents arriving in the dining room at the same time. As the residents found their seats, RN B unlocked the medication cart located at the	S 337	Residents Affected: There were no adverse effects noted to Resident 5 or Resident 1. RN B received education by the RN Clinical Supervisor on facility's medication administration policy and facility's insulin pen policy. RN B will also complete an insulin pen competency. Facility received an order from provider for resident 1 to track fluid intake independently. Resident given a notebook to utilize to track fluids and educated by RN Clinical Nurse Supervisor on how to track fluid intake. Nursing staff will enter total fluids in the MAR once per day. Licensed nurse will inform provider if resident is non-compliant or refuses fluid restrictions. Other Residents Potentially Affected: Residents who receive staff administered medications have the potential to be affected. There are two other residents with insulin pens.No adverse side effects noted to any residents who received medications during this medication pass. There are no other residents residing at Nano Nagle Village with fluid restrictions.	12/4/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Henrickson — TITLE: Administrator — (X6) DATE: 11/6/2026

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S 337	Continued From page 1 enterance to the dining room, opened a drawer and removed a medication cup labeled with a resident's name containing multiple medications in pill form. She locked the medication cart and delivered the medications to a resident in the dining room. She returned to the medication cart, unlocked the cart, opened the same drawer, in that drawer were several medication cups filled with medications. She removed another medication cup with multiple medications in pill form, she locked the medication cart and delivered the medications to another resident in the dining room. 2. Interview on 10/21/26 at 8:00 a.m. with RN clinical supervisor A revealed RN B should not have prepared the resident's medications prior to the residents being available for them to be administered. A facility policy was requested at that time. 3. Observation on 10/21/26 at 10:16 a.m. at the medication cart located near the nurses station revealed RN B gathered supplies to check resident 5's blood sugar and administer insulin if necessary. She entered resident 5's room, checked his blood sugar, and determined he was to receive 10 units of Lantus insulin. The insulin needle was placed on the insulin pen prior to entering resident 5's room. She used an alcohol swab to clean the resident's arm and then administered 10 units of Lantus insulin. She did not prime the pen prior to administering the insulin. 4. Interview on 10/21/26 at 10:20 a.m. with RN B revealed that she would prepare the residents' medications in medication cups labeled with their names before they arrived for breakfast. When she scanned the medication cards, the resident's	S 337	The Clinical Nurse Supervisor or designee will observe a medication pass for every nurse and medication aide who administers medications. The observer will verify that medications are prepared at the time of administration, that no cups are pre-poured or stored in the cart and that insulin pens are primed per the policy. Any concerns will be corrected at the time of the observation with immediate re-education. Systems to Prevent Reoccurrence: The Director of Nursing and RN Clinical Supervisor reviewed the Administration of Medication and Insulin Pen Medication Administration Policies; no revisions necessary. The facility adopted a fluid restriction policy for Assisted Living. All licensed nurses, medication aides and agency staff who administer medications will be educated on these policies, the five rights, no advance preparation of medications, insulin pen priming and Fluid Restriction Policy. Nutrition Services staff will be educated on the Fluid Restriction Policy. Staff not educated by 12/4/2026 will not work until this education is complete. Monitoring: The RN Clinical Nurse Supervisor or designee will observe 3 medication passes each week for 4 weeks then observe 5 medication passes per month for 3 months. Observations will include Employee B and insulin pen administration will be observed twice a week for 4 weeks, then four times a month for 3 months. Staff observed out of compliance will be re-educated immediately and re-observed within 7days. Clinical RN Supervisor or designee will audit fluid intakes entered into the MAR 3 times a week for 4 weeks, then 5 times a month for 3 months. The Director of Nursing will review audit results weekly and report out to the QAPI committee for further recommendations.	

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S 337	Continued From page 2 electronic medication administration record (eMAR) would timestamp that medication as administered to the resident, she would remove the medication from the card and place it in the medication cup. She would then place those medication cups in one drawer of the medication cart and lock the cart. As the residents entered the dining room, she would give the medication cups to the corresponding residents. If a resident refused their medication, she would document in their eMAR the reason they refused. She was familiar with the providers' policy on medication administration. She was aware that she was not supposed to prepare the residents' medications prior to administering them to the residents. She agreed she was not following the provider's policy. RN B acknowledged she did not prime the insulin pen prior to administering the insulin to resident 5. She agreed she should have dialed up two units of insulin and primed the pen prior to administration. 5. Review of the provider's January 2026 administration of medication policy revealed: "1. Only licensed nursing personnel and Certified Medication Aides may prepare, administer and record medication administration." "4. All medication administered must be recorded on the resident's electronic medication administration record (eMAR). 5. The nursing personnel administering the medication must verify the information on the medication card label with the medication administration record (eMAR). 6. The 'five rights' must be observed in giving each medication: the right medication, the right resident, the right time, the right route, the right	S 337		

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S 337	Continued From page 3 dose." "8. Only the nursing personnel preparing the resident's medication may administer it. The personnel administering the medication must document in eMAR after administering." "12. Medications may not be set up in advance." "18. Medication ordered for a particular resident may not be administered to another resident." 6. Review of the provider's December 2024 Insulin Pen Medication Administration policy revealed: "A. Assemble equipment and perform hand hygiene. B. Remove [the] paper tab from the outer shield of the pen needle. C. Inspect the insulin pen, if the insulin is cloudy, gently tip the pen 10 times and roll it between the palms of your hands 10 times to mix. D. Cleanse [the] needle hub with [an] alcohol wipe or CHG wipe [pre-moistened antiseptic cloths containing chlorhexidine gluconate]. Push or screw the new needle on to [onto] the pen before each injection. E. Remove the outer cap of the needle, then the inner shield. F. Dial two units on the pen and then press the button to shoot some insulin into the air to make sure it works. This is called 'priming' the pen. 1. NOTE: If you do not see at least two drops of insulin, repeat priming until insulin is seen. 2. If two drops are not seen after repeated priming do not use [the] pen. G. Dial up the dose of insulin according to provider order." 7. Review of the Lantus insulin pen instructions for use reveal: "STEP 3. PERFORM A SAFETY TEST. Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out,	S 337		

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S 337	Continued From page 4 repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again." B. Based on record review and interview, the provider failed to ensure the staff implemented and monitored the fluid intake for one of one sampled resident (1) with a physician's order for a 2000 milliliter (mL) fluid restriction who managed her own fluid restriction. Findings include: 1. Review of resident 1's care record revealed she had a diagnoses of congestive heart failure, bilateral lower limb edema [both lower legs had swelling], chronic renal insufficiency [long-term, progressive reduction in kidney function] and chronic kidney disease [a long-term condition in which the kidneys are damaged for at least three months and cannot filter blood properly, causing waste and fluid buildup in the body]. On 10/14/26, the resident scored fifteen out of fifteen on her cognitive screening, which indicated that she was not cognitively impaired. A 10/16/26 physician's order for a 2000 mL fluid restriction. The order did not indicate if the resident could self-monitor the fluid restriction. There was no record of the fluid restriction being implemented or documented in resident 1's care record. 2. Review of resident 1's care record and interview on 10/20/26 at 2:00 p.m. with registered nurse clinical supervisor (RN) A revealed resident 1 self-monitored the 2000 mL fluid restriction. The staff did not track or document how much fluid resident 1 consumed at meals, with medications,	S 337		

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S 337	Continued From page 5 or in her room. RN clinical supervisor A acknowledged the physician's order did not indicate the resident could self-monitor the fluid restriction. The staff did not request a physician's order for self-monitoring. RN clinical supervisor A did not document an assessment verifying resident 1 could monitor and manage a fluid restriction by herself. RN clinical supervisor A was familiar with resident 1 and felt resident 1 could manage her fluid restriction. RN clinical supervisor A agreed that the staff were responsible for ensuring the physician's orders were followed as ordered. 3. Interview on 10/20/26 at 3:15 p.m. with resident 1 and RN clinical supervisor A revealed resident 1 was self-monitoring her fluid restriction. Resident 1 knew she was only to consume 2000 mL of fluids in a day. She had a 1000 mL cup that she used to track her fluid intake. She did not document the amounts of fluids she consumed; she tracked the quantity in her head. She would start the day with a full 1000 mL of water. When she wanted fresh water, she would dump out what she did not consume and refill the water cup half full. She could refresh the water in her cup as frequently as she liked. She consumed approximately 1500 mL of water in her room. She consumed the other 500 mL of fluid at meals or with other liquids such as Gatorade. She was not sure how many milliliters were served at meals in the dining room. She knew she could not have a second glass at meals. She ate breakfast in her room and ate lunch and supper in the dining room. She admitted that she guessed sometimes about the amount of fluids she had consumed in a day. She could start documenting the amounts of fluids consumed so she knew precisely what she had consumed.	S 337		

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S 337	Continued From page 6 4. The provider did not have a fluid restriction policy for the assisted living facility. 5. The provider did have a January 2026 therapeutic diet policy (FN406) that stated, "Therapeutic diets must be ordered by the attending physician. The physician may delegate the task of prescribing a resident's diet to a registered or licensed dietician. A therapeutic diet is a diet intervention ordered by a health care practitioner as a part of the treatment for a disease or clinical condition manifesting an altered nutrition status, to eliminate, decrease, or increase certain substances in the diet."	S 337		