STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40127	A. BUILDING: _____ B. WING _____	C 10/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE ASSISTED LIVING	1010 W 5TH STREET REDFIELD, SD 57469

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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 from 10/5/26 through 10/7/26. Lakeside Assisted Living was found not in compliance with the following requirements: S169, S173, S200, S215, S295, S305, S478, and S685. 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 10/5/26 through 10/7/26. The areas surveyed included resident rights, quality of life, and personnel. Lakeside Assisted Living was found in compliance.	S 000		
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install or maintain door alarms for exterior openings (resident room windows). Findings include:	S 169		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kayla Jessen TITLE Administrator (X6) DATE 11/02/26

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S 169	Continued From page 1 1. Observation on 10/6/26 at 10:50 a.m. revealed the exterior windows for the residents' rooms were sliding windows with screens. The opening created by sliding the window to the fully open position measured approximately 24 inches by 24 inches. The sill of the window was about 3 feet above the floor. The window could be accessed as a non-monitored point of egress. 2. Interview with the administrator/owner A on 10/6/26 at 10:50 a.m. revealed the assisted living had residents with some cognitive impairment. The residents' rooms exterior windows could be considered unmonitored egress locations. The sliding windows would need limiters installed to prevent the windows from opening to the point where egress would be possible.	S 169	Limiters will be installed on all resident room windows to prevent window from being fully opened.	11/21/26
S 173	44:70:02:17(8-9) Occupant Protection The facility shall: (8) Ensure that any clothes dryer must have a galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in accordance with UL 2158A; and (9) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. A resident may store in the resident's room a maximum of three E-cylinders or seventy-two cubic feet, or 2.040 cubic meters of oxygen on an as-needed basis, in addition to oxygen in use by the resident. If a facility admits or retains a resident not capable of self-preservation, the facility must meet NFPA 101 Life Safety Code, 2012 edition,	S 173		

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S 173	Continued From page 2 health care occupancy standards in chapter 18 or 19, or equip the facility with complete automatic sprinkler protection. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install galvanized metal exhaust ductwork for one of two residential dryers in the laundry room (Maytag dryer). Findings include: 1. Observation on 10/6/26 at 10:40 a.m. revealed the laundry room had two residential style dryers. One of the dryers (Maytag brand) had foil paper exhaust ducting installed instead of metal pipe. Interview with administrator/owner A at the time of the above observation confirmed that condition.	S 173	Exhaust ducting will be replaced with approved transition duct.	11/21/26
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs.	S 200		

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S 200	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test documentation was not available). Findings include: 1. Record review on 10/6/26 at 10:15 a.m. revealed no documentation that quarterly flow testing was performed in 2025 and 2026 as required. 2. Interview with administrator/owner A on 10/6/26 at 10:20 a.m. revealed the provider was recently under new ownership.	S 200	Administrator will contact contractor (Automatic Building Controls, INC) to have quarterly flow testing completed. Documentation will be kept on file.	11/21/26
S 215	44:70:03:03 Fire Extinguisher Equipment Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet.	S 215		

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S 215	Continued From page 4 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain fire extinguishers as required (monthly inspection sign-offs). Findings include: 1. Observation on 10/6/26 at 10:15 a.m. revealed the fire extinguishers in the building were inspected by the outside contractor in January 2026 and had new inspection tags attached at that time. The inspection tags did not have monthly inspections (extinguisher gauge reading in the green and inverting the extinguisher to prevent settling of the contents) signed off with the date and the initials of the person doing the monthly inspection. Interview with administrator/owner A at the time of the observation confirmed that finding.	S 215	Fire extinguisher inspections will be done monthly by staff. Administrator will monitor this with the maintenance sheet.	11/21/26
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, interview, and policy review, the provider failed to ensure all required annual education subjects were completed for one of three sampled employees (B).	S 295		

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S 295	Continued From page 5 Findings include: 1. Review of the personnel record for employee B revealed she was hired on 12/30/14 as a registered nurse (RN). There was no documentation that she had completed annual training on the required subjects of fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety, resident rights, confidentiality, incidents and diseases subject to mandatory reporting, nutritional risks and hydration, abuse and neglect, problem solving and communication for residents with cognitive impairment or challenging behaviors, or oxygen therapy at any time since the last licensure survey on 6/14/23. 2. Interview on 10/6/26 at 10:55 a.m. with administrator/owner A revealed that she had been told by employee B and the previous facility owner that annual education was not required and that they would get sufficient education as part of the registered nurse licensure. She acknowledged that employee B did not complete annual training on the required subjects. 3. Review of the provider's undated Personnel Training policy revealed, "Ongoing in-services will be conducted. Attendance at in-services will be recorded for each employee and kept on file." It did not address which facility personnel were to attend the ongoing education in-services.	S 295	Employee B has completed annual education. All other employees were reviewed to ensure they had completed educational training requirements. Policy will be updated to include that all staff are required to complete yearly education. This will be monitored annually by the Administrator.	11/21/26
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel	S 305		

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S 305	Continued From page 6 must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review and interview, the provider failed to ensure one of five sampled employees (D) was evaluated by a licensed health professional within fourteen days of their hire date. Findings include: 1. Review of the personnel record for employee D revealed she was hired as a resident aide on 9/1/26. There was no documentation to support that she was evaluated by a licensed health professional to ensure she was free from communicable diseases within fourteen days of her date of hire. 2. Interview on 10/7/26 at 10:30 a.m. with administrator/owner A revealed that she expected new employees to be evaluated by the facility nurse within fourteen days of their hire date. She acknowledged that the health evaluation was not completed for employee D and should have been.	S 305	Employee D has been evaluated and results added to employee file. All other employees were reviewed to ensure they had evaluation by a licensed health professional. RN was educated with the expectation to complete evaluations of new employees with 14 days of hire date and will evaluate all new employees and provide documentation to the Administrator within 14 days of hire going forward. Policy was reviewed and revised to include evaluation of new employees within 14 days of hire date. Administrator will monitor to make sure each new employee file meets this requirement upon the hire of any new employee.	11/21/26
S 478	44:70:06:09 Written Menus A dietician shall annually approve, sign, and date each planned menu for all facilities except a facility without therapeutic diet services.	S 478		

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S 478	Continued From page 7 This Administrative Rule of South Dakota is not met as evidenced by: Based on license review, record review, and interview, the provider failed to ensure one of one registered dietitian (RD) (C) approved, signed, and dated the planned menus for 12 of 12 residents which included the optional service license for therapeutic diets. Findings include: 1. Review of the facility's 7/1/26 assisted living license revealed they were licensed for therapeutic diets. 2. Review of the menus provided by the facility on 10/6/26 revealed they were last signed by the RD on 5/2/23. 3. Interview on 10/6/26 at 11:55 a.m. and again at 3:30 p.m. with administrator/owner A confirmed that the menus were not signed by the RD since 2023. She verbalized that RD C had reviewed the binder containing the menus, but she did not know why the menus were not signed and dated indicating they were reviewed. Administrator/owner A was not aware that it was a requirement that the menus be approved, signed, and dated on an annual basis. 4. A policy regarding the facility menus or registered dietitian responsibilities was requested from administrator/owner A, but she indicated the facility did not have a policy.	S 478	Register Dietitian contacted to discuss signatures needing to be on the menus annually. RD states that annual review is included in the quarterly reports which are signed and dated. Menus will now be included for signature during her quarterly visit. A policy will be adopted by the facility to ensure compliance.	11/21/26
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely	S 685		

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S 685	Continued From page 8 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. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure safe self-administration of medication practices for one of three sampled residents (2) who did not have a physician's order or initial and quarterly self-administration assessments to indicate he was able to safely self-administer his medications. Findings include: 1. Review of resident 2's care record revealed he admitted to the facility on 5/18/26. His diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), dysphagia (difficulty with swallowing), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness with symptoms such as	S 685	Resident 2 has been evaluated for self-administration of medications and nebulizers, assessment has been added to his chart. All other residents were reviewed to ensure medication self-administration assessments were on file for those who needed them. RN will assess quarterly, the ability of residents to safely self administer medications and nebulizer treatments. Quarterly monitoring of this will take place via the resident roster and the Administrator will review to ensure completion. The facility will adopt a policy for Quarterly Assessments to be completed for all residents who self administer nebulizers or medications.	11/21/26

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S 685	Continued From page 9	S 685		

restlessness or irritability), and indigestion (abdominal discomfort during or after eating). His 5/18/26 short portable mental status questionnaire (SPMSQA) score was a 2, indicating intact intellectual functioning.

Resident 2's October 2026 medication list indicated he was prescribed Yupelri 175 milligram (mg)/3 milliliter (mL) by nebulizer once a day for COPD, albuterol 0.083% (percent) 2.5 mg/3 mL by nebulizer as needed every two hours for COPD exacerbation, chewable calcium antacid 500 mg/1 tablet as needed every four hours for indigestion, and Halls menthol cough drops one lozenge every two hours as needed. A 5/20/26 physician's order indicated that resident 2 was able to keep his cough drops and calcium antacid tablets at his bedside, and those instructions were also included on the medication administration record. There was no documentation of a physician's order for the resident to be allowed to self-administer his nebulized medications.

Resident 2's care record did not include an initial or quarterly self-administration of medication assessment for resident 2's Yupelri, albuterol, calcium antacid, and cough drops.

2. Interview on 10/7/26 at 10:30 a.m. with administrator/owner A revealed that resident 2 was allowed to self-administer the cough drops, antacid, and nebulizer medications after staff prepared them. Registered nurse (RN) B was responsible for completing the self-administration of medication assessments on a quarterly basis. Administrator/owner A acknowledged that the assessments should have been completed by RN B, but was unsure why they were missed for this resident.

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S 685	Continued From page 10 3. A policy regarding self-administration of medications was requested from administrator/owner A on 10/7/26 at 10:30 a.m., but she stated the facility did not utilize a policy.	S 685		