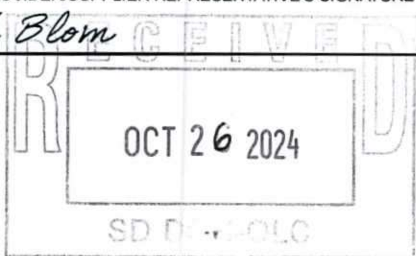
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46903	A. BUILDING: ______ B. WING ______	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT VILLAGE, INC	**613 WALNUT STREET YANKTON, SD 57078**

(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 10/1/24 through 10/2/24. Walnut Village, Inc. was found not in compliance with the following requirements: S030, S201, S202, and S337.	S 000		
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	On 10/04/24 Administrator reported elopement to DOH for incident on 7/15/24 and final report was accepted. The Elopement policy was modified to include "administrator will report all elopements to the DOH within 24 hours." Administrator will insure all elopements will be reported to DOH in the future.	10/04/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Josh Blom
TITLE: Joshua Blom - Administrator
(X6) DATE: 10/25/24



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This Administrative Rule of South Dakota is not met as evidenced by:
Based on record review, observation, interview, and policy review, the provider failed to report one of one elopement (a resident left the facility without staff knowledge) involving one of one sampled cognitively impaired resident (6) who was at risk for potential abuse and neglect to the South Dakota Department of Health (SD DOH).
Findings include:

1. Review of resident 6's care record revealed:
*His date of birth was 7/21/33.
*He was admitted on 8/30/22.
*His diagnosis included cognitive impairment.

Review of resident 6's 8/31/24 evaluation of care needs revealed:
*He was alert and oriented to person, date, and time but he thought he was on the farm 23 miles from [name of town in another state].
*Orientation was marked for he was "frequently forgetful or confused and needs substantial staff assistance to orient to person, place and/or time."
*He did not have a diagnosis of dementia.
*His Brief Interview for Mental Status examination score was seven indicating severe cognition impairment.
*Requiring an escort was marked yes for "resident needs a staff escort to BOTH meals and activities."
*Resident was a high fall risk.
-He had four documented falls over the past year.
-Fall risk interventions included escorts to the garden due to uneven ground and to assist caring for the garden.
-He had become more fatigued, his balance and gait had become worse and he was stooped and unsteady.
*Wandering was marked yes for "wanders but is

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easily redirected and does not attempt to wander off site."
-"He had one documented elopement from facility over the past year."

Review of resident 6's nursing observation revealed:
*On 7/15/24 at 7:02 p.m.: "Around 6:00 pm [staff initials] went into residents room to alert him it was time for dinner. Staff noticed residents pants were wet and helped change into clean clothing/depend. [Staff initials] reminded him again it was dinner time and left to gather more residents. [staff initials] was walking into the dining room and noticed resident [resident room number] was not in the room. [staff initials] checked premises and alerted [staff initials] and [staff initials]. The supervisor phone was called and alerted of situation.
[Staff initials] checked outside premises again, and noticed resident [room number on the bridge across the street. He stated to [staff initials] "I was looking for the place that looks like WV and stated to [staff initials] was looking for the church." [Staff initials escorted resident to the dining room to have dinner."
Incident Location: Off Premise
Day & Time of Incident: 7/15/2024 at 6:45 p.m.

Review of resident 6's 8/31/24 service plan revealed they had interventions in place for elopement.

Interview on 10/2/24 at 9:20 a.m. with administrator A regarding elopements revealed:
*He had not reported resident 6's elopement on 7/15/24 to the South Dakota Department of Health (SD DOH).
*He did submit reports to the SD DOH for changes in resident conditions.

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S 030	Continued From page 3 *If elopements became a problem with residents they looked for alternate placement for them. *Interventions put into effect immediately after resident 6 eloped on 7/15/24 had included: -An Apple air tag had been attached to his right knee brace and tucked under the Velcro strap. -Staff were doing "spot checks" on resident 6 frequently. *Resident 6 had no further elopements from the facility. Review of the provider's 11/21/23 Elopement policy revealed: *"It is the policy of [name of facility] to ensure safety and security to our residents." *"7. Administrator or RN [registered nurse] will contact the Department of Health within 24 hours to report a missing resident." Review of the provider's 9/2/22 Reporting Accident/Incident policy revealed "The Administrator, along with guidance from the RN, will determine if an accident/incident needs reported to the Department of Health."	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.	S 201		

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S 201	Continued From page 4 This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation testing and interview, the provider failed to maintain the required fire resistive design for two randomly observed hazardous areas (first floor laundry room and second floor former teachers' lounge) as required. Findings include: 1. Observation and testing on 10/2/24 at 10:35 a.m. revealed the door from the laundry room to the corridor was a fire-rated door. That door was provided with an automatic closer but was held open by a wedge placed under it. That wedge defeated the doors automatic closer and kept the door from latching into the door frame. That door is required to automatically close and latch into its frame to maintain the fire resistive design of the room. Interview with administrator A at the time of the observation confirmed that finding. 2. Observation on 10/2/24 at 12:21 p.m. revealed the former teachers' lounge room was over 100 square feet and had large amounts of combustibles. The size of that room and the volume of combustible items stored in it created a hazardous area. Testing of the north corridor door to that room at the same time revealed it had not been provided with an automatic closer, or any means for latching. That door also did not meet the fire restive rating required for a door on a hazardous area. Interview with administrator A at the time of the observation confirmed those findings. He stated he was unaware that amount of combustible storage in a room that large created a hazardous area.	S 201	On 10/03/24 Administrator removed door stop from laundry room door and former teachers lounge door. On 10/23/24 former teachers lounge was emptied of stored items which were removed from the facility. A door latch was installed by Hansen Locksmith on 10/24/24 for the teachers lounge door. The fire door to the 1st floor elevator was repaired on 10/4/24 to ensure a proper close and latch. The teachers lounge fire door doorstop was removed from the facility. The 3rd floor south fire door was repaired on 10/14/24 to ensure a proper close and latch. Administrator will conduct monthly fire door testing. Doors will be observed and tested monthly with the fire drill to ensure nothing is impeding the door to close and latch and that all fire doors are functioning properly. Repairs will occur as needed during monthly testing.	10/24/24

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S 201	Continued From page 5 B. Based on observation, testing, and interview, the provider failed to maintain the fire separation of the elevator shaft at two randomly observed locations (first floor and old teachers' lounge). Findings include: 1. Observation and testing on 10/2/24 at 12:14 p.m. revealed the fire-rated elevator lobby door to the first floor did not close and latch when released from the magnetic hold open device. Further testing of that door revealed it did not close and latch because the door would strike the door frame when closing. That door is required to automatically close and latch into its frame to maintain the fire resistive design of the elevator shaft. Interview with administrator A at the time of the observation confirmed those findings. He stated he had recently tested that door and it had operated properly. He further stated it was likely changes in humidity caused the building to shift. 2. Observation and testing on 10/2/24 at 12:23 p.m. revealed the fire-rated elevator lobby door to the old teachers' lounge did not close and latch when released from the magnetic hold open device. Further observation and testing of that door revealed it did not close and latch because the door was being held open with a wedge underneath it. That door is required to automatically close and latch into its frame to maintain the fire resistive design of the elevator shaft. Interview with administrator A at the time of the observation confirmed that finding. He stated he believed the former resident who primarily used that space is likely who placed that door wedge in	S 201		

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S 201	Continued From page 6 that location. C. Based on observation, testing, and interview, the provider failed to maintain the fire separation of the third floor at one observed location (South cross-corridor fire doors). Findings include: 1. Observation and testing on 10/2/24 at 1:15 p.m. revealed the fire-rated Cross-corridor doors in the south fire wall did not close and latch into the door frame when released from the magnetic hold open devices. Further testing of that set of doors revealed they did not close and latch because the door leaves would strike each other when closing. Interview with administrator A at the time of the observation confirmed those findings. He stated he had recently tested that door and it had operated properly. He further stated it was likely changes in humidity caused the building to shift.	S 201		
S 202	44:70:03:02 General Fire Safety At least two personnel must be on duty at all times, unless the department has approved a staffing exception requested by the facility. In a multilevel facility, at least one personnel must be on duty on each floor containing occupied beds. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, resident identification roster, and license, the provider failed to maintain staffing on each floor of the building at all times. Findings include: 1. Interview on 10/1/24 at 9:00 a.m. with administrator A and director of nursing (DON) B	S 202	On 10/03/24 Administrator instructed all staff to report to their assigned floors for shift change and to remain on assigned floor for duration of shift. Kitchen staff was assigned the duty of dishwashing all dishes so staff could remain on assigned floor for duration of shift.	10/03/24

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confirmed they had assisted living residents on all three floors of the facility. Each floor had been staffed at all times.

2. Review of the current resident list provided by DON B on 10/1/24 at 10:30 a.m. revealed they had identified eleven residents as being cognitively impaired. Of those eleven residents five residents resided on the first floor, two residents resided on the second floor, and four residents resided on the third floor.

3. Review of the provider's Assisted Living Center License revealed they had been approved for additional services for cognitively impaired residents.

4. Observation and interview on 10/1/24 from 1:41 p.m. through 2:11 p.m. on the third floor foyer area revealed:
*At 1:41 p.m. certified medication assistant (CMA) D was standing by the elevator. Interview at that time revealed she was going to the first floor for the change of shift report. She stated "Typically there was twenty minutes when no one was on the third floor during the change of shifts." She confirmed there would not be another staff member on the floor at that time. CMA D then got on the elevator and left the third floor.
*At 1:43 p.m. a contracted physical therapist was looking for a resident. She confirmed she was contracted and not employed by the facility.
*At 1:45 p.m. administrator A had been on the third floor but was observed leaving the third floor.
*At 1:50 p.m. resident 2 was in the hallway by the elevator.
*At 2:11 p.m. CMA E exited the elevator and confirmed she was the third floor attendant for the evening shift.

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S 202	Continued From page 8 5. Interview on 10/2/24 at 8:40 a.m. with CMA C regarding staffing coverage on all three floors revealed: *She worked all three shifts. *At shift change everyone met on the first floor front room area. *Confirmed no one had been monitoring the second and the third floor during the change of shift's. Interview on 10/2/24 at 9:30 a.m. with administrator A regarding maintaining staffing on all three floors at all times revealed: *He confirmed they had cognitively impaired residents in the facility. *There were times throughout the day when there was no attendant on the second or the third floor due to changing of shifts or when staff would be assisting with washing dishes following meal time.	S 202	On 10/21/24 DON updated policy on Insulin Administration. DON began training all Med Aide and R/Ns on staff on proper insulin pen usage on 10/21/24 and has trained all full and part time staff as of 10/25/24. PRN staff will receive training on their next scheduled shift by DON. RN will ensure med aide competency with routine med passes and annual training.	10/25/24
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 observation, care record review, interview, policy review, and manufacturer's recommendation review, the provider failed to ensure insulin pen preparation and administration for one of one sampled resident (1) by one of one observed certified medication assistant (CMA)	S 337		

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(C) had been completed according to the manufacturer's instructions to ensure an accurate dose had been given.
Findings include:

1. Observation on 10/2/24 at 8:40 a.m. in the secluded area of the dining room with resident 1 and CMA C during medication administration revealed:
*CMA C took the Lantus insulin pen out of the medication cart.
-Dialed the insulin pen to 37 units.
-Handed the insulin pen to resident 1.
-CMA C had not primed the pen prior to handing the insulin pen to resident 1.
*Resident 1 then self-administered the insulin.

Review of resident 1's care record revealed:
*A 7/10/24 physician's order to increase Lantus to 37 units in the a.m. and 23 units in the p.m.
*A 9/10/24 self-administration assessment indicating she was safe to continue with Lantus insulin injections.

Interview on 10/2/24 at 8:45 a.m. with CMA C regarding the preparation of insulin pens revealed she had not been trained on priming the insulin pen by wasting two units of insulin prior to administering the allotted amount of insulin from the pen.

Interview on 10/2/24 at 8:55 a.m. with director of nursing (DON) B regarding preparation of insulin pens revealed she had not been aware the needle should have been primed prior to setting the dose and administering the insulin to ensure accurate dosing.

Review of the provider's 9/2/23 Insulin Administration policy revealed:

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S 337	Continued From page 10 *3. "The RN (registered nurse) or medication aid will: -iii. Dial the insulin pen to the proper dosage as directed on the MAR (medication administration record). -iv. Take the insulin to the residents apartment. -v. Observe the resident self-administer the insulin." On 10/2/24 at 9:00 a.m. DON B removed the manufacturer's instructions for Lantus pre-filled syringes from the unopened box and handed it to the surveyor. Review of the Lantus pre-filled syringe manufacture's instructions revealed: *"Step 3: Do a safety test. -Always do a safety test before each injection to: --Check your pen and the needle to make sure they are working properly. --Make sure that you get the correct Lantus dose." *"3A: Select 2 units by turning the dose selector until the dose pointer is at the 2 mark. -3B: Press the injection button all the way in. --When insulin comes out of the needle tip, your pen is working correctly. --If no insulin appears you many need to repeat this step up to 3 times before seeing insulin." *"Step 4: Select the dose."	S 337		