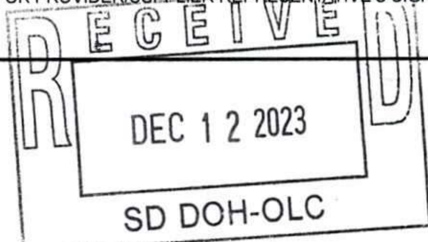
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53872	A. BUILDING: ___ B. WING ___	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HILLS RETIREMENT COMMUNITY	2711 HIGHWAY 18 WEST HOT SPRINGS, SD 57747

(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 11/7/23 through 11/8/23. Pine Hills Retirement Community was found not in compliance with the following requirements: S080, S085, S200, S201, S215, S280, S331, S337, S375, S381, S450, S503, S506, S621, S642, S670, S680, S681, S685, S701, and S1038. 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 11/7/23 through 11/8/23. The area surveyed was resident care. Pine Hills Retirement Community was found in compliance.	S 000		12/23/2023
S 080	44:70:02:02 Pets No pet kept in or visiting a facility may negatively affect the well-being of any resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure a pet had been vaccinated for one of one sampled resident (11) who had a cat. Findings include: 1. Observation on 11/7/23 at 9:05 a.m. revealed resident 11 had a sign by her door that indicated she had a cat. Interview on 11/8/23 at 3:17 p.m. with human resources D regarding pet vaccination records for resident 11's cat revealed he was not able to find any vaccination records on file.	S 080	S080: All pets are currently vaccinated. Business Office Manager will audit all new and existing pets monthly x 4 to bring to monthly QA meeting. Human resources D/BOM will audit all new and existing pets monthly x 4 to bring to monthly QA meeting. Human resources D (also BOM) has reviewed job description and job duties.	12/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vickie Nekuda TITLE: ED (X6) DATE: 12/12/2023



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S 080	Continued From page 1 Interview on 11/8/23 at 3:18 p.m. with executive eirector A regarding pet vaccination records for resident 11 revealed: *Resident 11 was admitted on 2/27/23. *Her family brought her a cat shortly after that time. -She was unsure of the exact date the cat was brought in. *Resident 11's family had said the cat was vaccinated. -They would bring in the vaccination record but had not. Review of the provider's 9/16/22 Pet Policy revealed: *"These policies take into account the needs of management, pet owning tenants and non-pet owning tenants, as well as the needs of the pets themselves. The intent of this policy is to create harmonious co-existence of all in our community living situation by fostering an attitude of respect, cooperation and consideration." *"5. All pets must receive proper veterinary care, and must be up-to-date on rabies and distemper vaccinations, with a veterinarian's statement to this effect provided to management."	S 080		
S 085	44:70:02:03 Cleaning methods and facilities The facility shall have supplies, equipment, work areas, and complete written procedures for cleaning, sanitizing, or disinfecting all work areas, equipment, utensils, and medical devices used for residents' care. Common use equipment shall be disinfected after each use. This Administrative Rule of South Dakota is not met as evidenced by:	S 085	S085: New mop heads have been ordered for all housekeeping staff. Executive Director will provide education for all housekeeping staff on Environmental policies. Executive Director will audit that mop heads and water are being changed per policy weekly x 4 and montly x 4 to be brought to monthly QA meeting.	12/23/2023

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S 085	Continued From page 2 Based on observation, interview, and policy review, the provider failed to prevent potential cross-contamination for cleaning and disinfection during floor care during one of one randomly observed resident's room cleaning by housekeeper M. Findings include: 1. Observation and interview on 11/8/23 at 12:40 p.m. with housekeeper M revealed: *There was a mop bucket with water and a mop in it in the hallway outside a resident's room. *The floor cleaner product they used was 3M Quat disinfectant. -The product was mixed with water in the mop bucket. *The housekeeper mopped the resident's room and bathroom with the same mop and mop water from the hallway. *He reported they changed the mop water between every two or three resident's kitchens and bathrooms. *He used the same mop head for all of his floor cleaning for the day throughout the facility. *At the end of the day he took off the mop head, placed it in the soiled laundry room and then it was laundered in the washing machine. *He had worked in housekeeping for about three weeks and had received his training from housekeeper N. Interview 11/8/23 at 1:10 p.m. with housekeeper N revealed: *She had trained housekeeper M. *She reported they changed the mop water between every two or three residents' kitchens and bathrooms. *She used the same mop head for all her floor cleaning for the day throughout the facility. -The mop heads were washed in the morning before being used.	S 085	S085 continued Executive Director and Director of Nursing reviewed and revised environmental policies. One batch of mop heads have been received and we are expecting another batch to be delivered in the next week. All mop heads will be received by final correction date. Revisions to environmental policies include mop head changing as well as when mop bucket is to be changed. All mop heads will be received by final correction date.	12/23/2023

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S 085	Continued From page 3 *She had worked for the provider for about "ten years" and had been trained by housekeeper O. *Housekeeper O oversaw the housekeeping department. Interview on 11/8/23 at 1:23 p.m. with housekeeper O revealed she: *Reported they changed the mop water between every three rooms or as needed. *Was not certain if there were policies and procedures for housekeeping. *Normally trained new housekeepers but had not trained housekeeper M. Interview on 11/8/23 at 3:00 p.m. with executive director (ED) A regarding the process for environmental floor cleaning and disinfecting revealed: *She was aware the housekeepers used the same mop water for two to three resident rooms and bathrooms before changing it, but she had not realized they used the same mop head to clean floors for the entire day. -She though using the same mop head the potential to cause cross-contamination and was concerned. -She stated, "This is how it had always been done." *She agreed proper disinfection was not occurring throughout the facility for floors. Review of the provider's 4/15/14 Cleanliness/Sanitation of Facility policy revealed: *"Policy: It is the policy of this facility to maintain a design and construction that minimizes the sources and transmission of infectious diseases to residents, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation."	S 085		

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S 085	Continued From page 4 Review of the provider's 5/18/21 Infection Control policy revealed: *"Additional procedures for infection control in housekeeping/laundry department:" -"5. Follow community's policy for proper environmental cleaning and disinfecting for the dept [department]." Interview on 11/8/23 at 3:10 p.m. with executive director A regarding additional environmental and disinfecting community policies revealed they did not have any.	S 085		12/23/2023
S 200	44:70:03:01 General fire safety Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition. An automatic sprinkler system is not required in existing facility unless significant renovations or remodeling 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 occurs. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to maintain three feet of clear working space in front of the electrical panels in one of one areas (the maintenance office). The provider must comply with the National Fire Protection Association (NFPA 70), National Electrical Code (NEC) article 110.26(A)(1) Depth of Working Space. Findings include: 1. Observation on 11/7/23 at 1:15 p.m. revealed	S 200	S200: Electrical panels have been cleared of all obstructions. Unsealed openings above lay-in ceiling in garden level have all been sealed. Maintenance manager P will check space in front of electrical panels monthly. Monthly checklists were reviewed with maintenance manager P with understanding voiced. Monthly checklists will be brought by maintenance manager P to monthly QA meetings x 4.	12/23/2023

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S 200	Continued From page 5 the electrical panels in the maintenance manager's office were obstructed by plastic totes, electrical cords, vacuum cleaner, cardboard boxes of supplies, and a small pet carrier. There was not a minimum three feet of clear working space provided at any electrical panel in the room. Interview with the maintenance manager (P) at the time of the observation confirmed that finding. B. Based on observation and interview, the provider failed to maintain the 30 minute fire-resistive rating of smoke barrier walls. One of two smoke barrier walls had unsealed openings around penetrations above the lay-in ceiling. Findings include: 1. Observation on 11/7/23 at 1:30 p.m. revealed the garden level west smoke barrier wall had unsealed openings above the lay-in ceiling around a two-inch diameter copper pipe and a computer cable. Interview with the maintenance manager at the time of the observation confirmed that finding. This deficiency could potentially affect all residents of the smoke compartment.	S 200		
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 fire alarm system must be sounded each month.	S 201	S201: Strobe lights on second floor west hall have been repaired. Smoke detectors sensitivity values have been obtained from Nebraska Safety and Fire Equipment. These values were completed in December 2022 and are next due for testing December 2024. Strobe lights are checked with monthly fire drills. Maintenance manager P was educated on importance of monthly fire drill	12/23/2023

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S 201	Continued From page 6 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, document review, and interview, the provider failed to maintain the fire alarm system as required (strobe devices on second floor west and all smoke detector sensitivity values) for 2022 and 2023. Findings include: 1. Observation on 11/7/23 at 3:00 p.m. revealed the fire alarm strobe lights on the second floor west did not function when the fire alarm was activated for the fire drill. Failure to maintain the fire alarm system as required increased the risk of death or injury due to fire. 2. Document review on 11/7/23 at 3:30 p.m. of the contractor's report dated 12/2/22 revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide sensitivity values for the smoke detectors, only pass/fail comments. The maintenance manager was present when the deficiency was identified. Failure to maintain the fire alarm system as required increased the risk of death or injury due to fire. 3. Interview with the maintenance manager (P) at the time of the observation and document reviews confirmed those findings. The deficiencies affect all notification and detection devices of the fire alarm system. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	S 201	S201 continued completion and monthly checklists reviewed. Maintenance manager P will bring monthly checklists to monthly QA meetings x 4.	12/23/2023

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S 215	44:70:03:03 Fire extinguisher equipment Fire extinguisher equipment shall be installed and maintained by 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. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain five randomly observed fire extinguishers (garden level) as required as part of a preventative maintenance plan. Findings include: 1. Observation on 11/7/23 beginning at 1:35 p.m. revealed the fire extinguishers in the garden level (lowest floor) of the building had not been signed off for maintenance checks since July 2023. Further observations on that same day revealed that same condition existed for other fire extinguishers. Interview with the maintenance manager (P) at the times of the observations confirmed those findings. He revealed he was a new employee in September 2023.	S 215	S215: Business Office Manager will audit monthly fire extinguisher inspections monthly x 4. Audits will be brought to monthly QA meetings. Maintenance manager P will be responsible for checking fire extinguishers monthly. Maintenance manager P has been educated on the importance of completing monthly checklist. Maintenance manager P will bring monthly checklist to monthly QA meeting x 4.	12/23/2023

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S 215	Continued From page 8 This deficiency could potentially affect all residents of the facility.	S 215		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and job description review, the administrator failed to manage the facility in a manner that ensured the overall daily operation of the facility, appropriate resident care, resident safety, and maintained compliance with the Administrative Rules of South Dakota (ARSD) 44:70 Assisted Living Center (ALC) regulations. Areas of concern included the following: *Environmental services. *Fire safety. *Quality assessment and assurance. *Tuberculosis screening. *Adherence to professional standards of practice for unlicensed assistive personnel (UAP). *Discharge planning. *Dietary services, dietary staff education, and dietary staff training. *Medication management including medication administration practices, self-administration of medications, control and/accountability of medications, monthly medication review process,	S 280	S280: The Executive Director with the assistance of the Director of Nursing will ensure all audits, policies/procedures, staff education and QA are completed as stated in the Plan of Correction for survey on 11/08/2023. Executive Director will audit designated employees for audit completion weekly x 4 and monthly x 4. Executive Director will bring all audits to monthly QA meeting. Executive Director will collect the following audits from designated employees at monthly QA meeting to ensure all departments are in compliance: Human Resources D/BOM - Pet Vaccination Audit Human Resources D/BOM - Fire Extinguisher Audit Human Resources D/BOM - Employee/Resident TB Audit Human Resources D/BOM - Dietary orientation Audit Human Resources D/BOM - UAP Competancy Audit Director of Nursing - Medication Storage Audit Executive Director and Director of Nursing were given updated ARSD 44:70 ALC Requirements during original survey. Updated ARSD has been reviewed including updated policies. Monthly QA will review updated education provided and audits provided to determine if when substantial compliance has been reached.	12/23/2023

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S 280	Continued From page 9 and UAP training. *Care record documentation. Findings include: 1. Interview on 11/8/23 at 3:30 p.m. with executive director A revealed she: *Communicated with the facility's owner on a weekly basis but that he only wanted to be involved with business-related manners. *Was responsible for ensuring the overall day-to-day operation of the facility. *Confirmed the concerns identified during the survey. *Was aware of the ARSD 44:70 ALC requirements the facility was expected to follow. Review of the January 2018 executive director job description revealed: *Summary/Objective: -"The primary purpose the Executive Director is to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing and/or assisted living facilities to assure the highest degree of quality care can be provided to the residents at all times." Refer to S080, S085, S200, S201, S215, S331, S337, S375, S381, S450, S503, S506, S621, S642, S670, S680, S681, S685, S701, and S1038.	S 280		
S 331	44:70:04:10 Tuberculin screening requirements Tuberculin screening requirements for healthcare employees or residents are as follows: (1) Each healthcare employee or resident shall receive an annual individual TB risk assessment that is documented and the two-step	S 331	S331: A Licensed Nurse will be responsible to conduct tuberculosis screening for all new employees, residents and volunteers. Business Office Manager will audit new employees/residents weekly x 4 and monthly x4. Audits will be brought to monthly QA meeting. Employee L TB screening test was found in wrong file.	12/23/2023

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S 331	Continued From page 10 method of tuberculin skin or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12-month period prior to the date of admission or employment are considered a two-step. A TB blood assay test completed within a 12-month period prior to the date of admission or employment is considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation of the last skin or blood assay TB testing completed within the prior 12 months. Skin testing or a TB blood assay test is not necessary if documentation is provided of a previous positive reaction to either test. Any healthcare employee or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall 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 employee personnel record review, interview, and policy review, the provider failed to ensure one of three sampled employees (L) had received a tuberculin (TB) screening test within 14 days of hire. Findings include: 1. Review of employee L's personnel record revealed: *She was hired on 4/6/23. *There was no documentation to support she had received a TB screening test.	S 331	S331 Continued Director of Nursing will be responsible to conduct tuberculosis screening for all new employees, residents and volunteers. If facility nurse is not available, the tuberculosis screening will be completed at local Fall River Clinic. Director of Nursing has reviewed ARSD 44:70 regulations on tuberculin screening. Pine Hills does not have other nurses on staff.	12/23/2023

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S 331	Continued From page 11 Interview on 11/8/23 with director of nursing (DON) B regarding TB screening tests revealed: *She was responsible to complete the TB screening test for employee L. -She thought she had completed it. *She confirmed there was no documentation to support that it was completed. Interview on 11/8/23 at 3:06 p.m. with executive director A regarding TB screening tests revealed: *DON B was responsible to complete the TB screening tests for new employees. *ED A confirmed there was no documentation to support employee L had received a TB screening test. Review of the providers 5/14/21 TB Symptomatic Screening For Residents and Staff Policy revealed: *"It will be the responsibility of the Manager or designee to:" -"2. Conduct Mantoux testing [TB] for all new employees, residents, and volunteers." *"Procedure: -1. Each new employee ...shall receive the two-step method of Mantoux skin test to establish a baseline within fourteen (14) days of employment or admission."	S 331		12/23/2023
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:	S 337	S337: Director of Nursing will provide education with all UAP staff on tasks that may and may not be delegated to them. Director of Nursing will bring training attendance and inservice materials to monthly QA meeting. Director of Nursing will provide education with all UAP staff on medication administration routes. Director of Nursing will bring UAP training certificates on completion to monthly QA meeting. No other licensed staff to include in education at this time.	12/23/2023

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PINE HILLS RETIREMENT COMMUNITY	2711 HIGHWAY 18 WEST HOT SPRINGS, SD 57747

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S 337	Continued From page 12	S 337	S337 continued	12/23/2023

Based on observation, interview, job description review, and policy review, the provider failed to ensure:
*Splitting a pill and calculating a medication dose had not occurred by one of one unlicensed assistive personnel (UAP) (J) for one of one observed resident (5). That was a trask that should not have been delegated by the licensed nurse.
*Professional standards of practice had been followed for eye drop administration by one of one UAP (I) for one of one observed resident (8).
Findings include:

1.Observation and interview on 11/7/23 at 11:45 a.m. with UAP J during resident 5's medication administration revealed:
*The resident's medication pass had included the administration of one-25 milligram tablet of metoprolol with instructions to "Give 1/2 tab."
-After removing one tablet from the medication bottle UAP J used the pill splitter to halve the tablet.
*She stated director of nursing (DON) B had usually halved the metoprolol tablets inside the bottle but that had not been done.

2. Observation and interview on 11/7/23 at 5:15 p.m. with UAP I who administered resident 8's eye drops revealed:
*The resident's eyedrops were administered into the inner most corner of each of the resident's eyes.
*UAP I had known the expectation for eye drop administration was to have lowered the skin beneath the center of the lower lid and administer the drop inside that pocket.
-She felt the resident was able to "blink it in better" using her method and she felt "uncomfortable pulling the [lower] eyelid down" for

Provider's plan of correction (S 337 continued):

Resident 5 has had his medication split by Director of Nursing per policy.

Three UAPs will be observed during medication passes by Director of Nursing each week x 4 and monthly x 4.

All residents have been reviewed for any medications that may not have been split prior to delivery.

All UAPs have been instructed to bring any medication needing to be split to the Director of Nursing to be halved.

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S 337	Continued From page 13 eye drop administration. Interview on 11/8/23 at 3:00 p.m. with DON B regarding the observations referred to above revealed: *It was her responsibility to halve medications according to a physician's order if the resident's pharmacy had not already packaged it that way. -It was not the role of the UAP to have done that because it was considered dose calculation. *Eye drops were expected to have been instilled in the pocket created by drawing down the lower lid. Review of the revised 4/18/14 Medication Aide (UAP) job description revealed: *"6. The Medication Aide is responsible for observing symptoms and responses to medication and for reporting them to the professional nurse." *"The Medication Aide may not perform the following:" "3. Calculation of a medication dose." Review of the revised 4/17/14 Eye Drop Medication Administration policy revealed "6. Have resident tilt head backward and draw down lower lid to form pocket" in which to instill the eye drops.	S 337		
S 375	44:70:04:15 Quality assessment Each facility shall provide for on-going evaluation of the quality of services provided to residents. Components of the quality assessment evaluation shall include establishment of facility standards; review of resident services to identify deviations from the standards and actions taken to correct deviations; resident satisfaction surveys; utilization of services provided; and	S 375	S375 The Executive Director and Director of Nursing will conduct monthly QA meetings to review all audits within the plan of corrections and any new concerns. The QA committee will include,but not limited to: Executive Director Director of Nursing Kitchen Manager Plant Operations Business Office Manager An annual checklist will be made to log QA projects and ensure they are completed on an annual schedule: Nursing two times a year Food Service annually Activities annually Environmental Services annually	12/23/2023

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S 375	Continued From page 14 documentation of the evaluation and report to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to maintain an effective quality assurance (QA) program to evaluate and maintain the following: *Environmental services. *Fire safety. *Tuberculosis screening. *Adherence to professional standards of practice for unlicensed assistive personnel (UAP). *Discharge planning. *Dietary services, dietary staff education, and dietary staff training. *Medication management including medication administration practices, self-administration of medications, control and accountability of medications, monthly medication review process, and UAP training. *Care record documentation. Findings include: 1. Interviews during the survey on 5/7/23 and 5/8/23 with executive director (ED) A and director of nursing (DON) B revealed: *Multiple concerns were identified including the areas listed above. *There had not been an effective QA program in place to evaluate the facility's quality of care and services. Interview on 11/8/23 at 3:30 p.m. with ED A revealed: *The QA committee met monthly. *QA meetings were attended by the department heads. *The standing agenda for each meeting included:	S 375	S375 continued Director of Nursing will do minutes at each monthly QA meeting.	12/23/2023

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S 375	Continued From page 15 -Review of the most recent (2/13/21) state licensure survey citations that included the folloiwng: --S303, S096, S105, S185, S202, S280, S296, S305, S337, S342, S415, S468, S498, S506, S633, S654, S685, S820, S875. -Concerns brought forward by the department heads. -Infections of residents that DON B tracked. *There was no implementation of performance improvement plans. -They were not gathering any audit data or other information related to any resident care areas. *The most recent meeting was held on 10/25/23. -There were no meetings minutes associated with that meeting. Review of the provider's 5/14/21 Quality Assessment Program policy revealed: *"The purpose of the Assisted Living CQI/QA Committee at the Facility will be to objectively and systematically audit, evaluate, and/or review the quality of resident care provided. The members of the CQI/QA Committee will include but is not limited to: -Executive Director/Administration -Nursing Designee -Activities Designee -Food Service Designee -Housekeeping -Plant Services *CQI/QA projects, reports, and audits will be completed on the following schedule: -Nursing Two times per year -Food Service Annually -Activities Annually -Environmental Services Annually *These are minimum requirements; each department shall use their discretion to conduct more frequent standards of review. A rolling log	S 375		

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S 375	Continued From page 16 will be maintained to ensure compliance with requirements. *Meetings will be held on a routine basis every six months with additional meetings as directed by the committee should significant findings be realized." Refer to: S080, S085, S200, S201, S215, S280, S331, S337, S375, S381, S450, S503, S506, S621, S642, S670, S680, S681, S685, S701, and S1038.	S 375		
S 381	44:70:04:16 Discharge planning The facility shall initiate planning with applicable agencies to meet identified needs and a resident must be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care must be made available to whomever the resident is discharged and to referral agencies as provided by the discharge plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on closed electronic care record (ECR) review, interview, and policy review, the provider failed to ensure one of one sampled resident (9) had received discharge planning prior to her discharge from the facility. Findings include: 1. Review of resident 9's closed ECR revealed: *She was admitted on 6/7/23. *She was discharged to home on 6/30/23. *There was no documentation to support a discharge plan had been developed for her. Interview on 11/8/23 at 10:00 a.m. with director of nursing B regarding discharge planning for	S 381	S381: Director of Nursing will complete discharge planning on all current assisted living residents. All new admissions will have discharge planning completed within first forty eight hours. Executive Director will audit weekly x 4 and monthly x 4. Audits will be brought to monthly QA meeting. Director of nursing will complete Relias education on discharge planning. Completion certificate will be brought to monthly QA meeting. Referral agency list will be available to all residents. ED will be auditing discharge plan completion weekly x 4 and monthly x 4.	12/23/2023

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S 381	Continued From page 17	S 381		

residents revealed:
*She was responsible for the discharge planning for residents.
*No discharge plan was completed for resident 9.
*There were no discharge plans for any of the current residents.

Review of the provider's 5/17/21 Discharges policy revealed:
*"Within 48 hours after admission, an assisted living center must determine a resident's potential for discharge. The facility must initiate planning with applicable agencies to meet identified needs, and patients and residents must be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care must be made available to whomever the patient or resident is discharged and to referral agencies as required by the discharge plan."
*Discharge initiated by resident and/or family
-For any discharge from the assisted living that is initiated by the resident and/or family, the Community will require at least 30 days written notice. Administration will provide or facilitate sufficient preparation and orientation, in conjunction with Nursing, to ensure a safe and orderly discharge, and will document such in the clinical record."

Interview and policy review on 11/8/23 at 3:07 p.m. with executive director A regarding discharge planning revealed she:
*Was not certain if they assisted residents with discharge planning.
-She stated, "Most residents plan on remaining here until they pass away."
--She had not felt that discharge planning was necessary.
*Confirmed no discharge planning had occurred

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S 381	Continued From page 18 for resident 9 or any other resident. *There was no listing of referral agencies to assist residents with their identified needs after they were discharged.	S 381		
S 450	44:70:06:01 Dietetic services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of §44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions for meal service, food storage and preparation had been maintained related to the following: *One of one resident (12) who required a modified diet texture had one of one observed meal prepared in a manner to preserve its nutritional value and flavor. *Sanitary food storage and food safety practices had been implemented for: -Pans of dessert prepared for one of one observed meal service. -Two of three bulk storage containers. -One of one ice machine. *One of one stand mixer. *Appropriate glove use by one of one kitchen cook/server E during one of one observed meal service. *One of one salad bar cart was maintained in a	S 450	S450: Dietitian will provide education to dietary staff on modified diets. Monthly inservice and education training for all dietary staff; topics to include nutrition and food safety, sanitation, food preparation and handling, hygiene and cleaning. All dietary cooks will complete ServSafe Food Protection Course. All other dietary staff will complete Food Handler Certificate course. All inservice attendance sheets and education certificates to be brought to monthly QA meeting. Executive Director will audit kitchen weekly x 4 and monthly x4 for sanitation and food temping. Executive Director and Registered Dietitian will implement a salad bar policy. Registered dietitian has provided education to dietary staff on modified diets on 11/29/2023. Dietary cooks started taking ServSafe courses on 12/4/2023 to be completed by 12/15/2023. Kitchen Supervisor C will educate all dietary staff on salad bar policy. Kitchen Supervisor C will bring education attendance sheets to monthly QA meeting. Newly hired kitchen lead (ServSafe manager certified) will audit three randomn weekly shifts x 4 weeks for proper preparation of modified diet textures, sanitary and safe food storage, proper glove use and proper set up/take down of the salad bar and three randomn weekly shift x 4 months thereafter. Audits will be turned into the Executive Director who will then bring them to the monthly QA meeting.	12/23/2023

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safe and sanitary manner during two of two observed meal services.
Findings include:

1. Observations on 11/7/23 at 10:00 a.m. in the kitchen revealed the following:
*Baking pans of pre-cut dessert bars for the noon-time meal sat uncovered on top of a microwave along a metal countertop.
-The noon-time meal began at 10:45 a.m.
*There was a large plastic covered storage container of sugar with a plastic beverage cup sitting inside of it.
*There was a large plastic covered storage container of flour with a plastic beverage cup sitting inside of it.
*The back splash attachment of the stand mixer and the part of the mixer where the mixing beaters attached had spatterings of what appeared to have been dried food.

During preparation of resident 12's noon-time meal at 11:00 a.m. kitchen cook/server F:
*Removed cooked diced ham from the refrigerator and placed it in a food processing machine.
-Added tap water to the food processor in order to achieve the pureed consistency for that ham.

While preparing noon-time beverages for residents at 11:05 a.m. kitchen cook/server E:
*Used stacked plastic drinking cups to scoop ice from the ice machine into each of those cups instead of using an appropriate scoop to put ice into the cups.
-Beverages were added to those same cups and served to the residents at their noon-time meal.

During plating of the noon-time meal at 11:15 a.m. kitchen cook/server F:

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*With gloved hands she retrieved a rag from inside a bucket marked "sanitizing solution" and wiped the counter attached to the front of the steam table.
-Without changing those gloves after sanitizing the counter she placed buns that were going to have been served for the noon-time meal onto individual residents' dinner plates.

2. Observations on 11/7/23 of the portable salad bar cart in the kitchen revealed:
*At 10:00 a.m. the cart had been filled with uncovered, individual containers of salad bar food items including lettuce, fresh fruit and vegetables, boiled eggs, salad dressings, cottage cheese, and pasta salads.
-The individual food containers sat inside the trough on the salad bar cart that was filled with ice.
*There was a clipboard on the side of a refrigerator with a "November 2023 Salad Bar Temp Log" form attached to it.
-There was no recorded temperature data for the month of November 2023 on that form.
*At 11:05 a.m. the cart was moved out to the main dining room for the noon-time meal service.

Observation and interview on 11/7/23 at 4:30 p.m. with kitchen cook/server E in the kitchen revealed:
*He was washing his hands.
-The salad bar cart containing uncovered individual containers of salad bar food items were "parked" within two feet of that handwashing sink, within one foot of a covered garbage can, and in front of the three-compartment sink.
*Kitchen cook/server E stated each of the salad bar food containers had lids.
-At the end of the noon-time and evening food services those containers should have been

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covered, removed from the salad bar cart, and placed in the walk-in refrigerator for storage.

Observation and interview on 11/8/23 at 10:10 a.m. with kitchen cook/server G in the kitchen revealed:
*Individual containers of covered salad bar food sat on ice inside of the salad bar cart.
*Kitchen cook/server G stated:
-The individual food containers on the cart were not date marked and staff would not have known how long any food item had been on that cart.
-He was not sure how many times the contents of the food containers had been re-served to residents before they were discarded.
-"If I wouldn't eat it - I wouldn't serve it [to the residents]."

3. Interview on 11/8/23 at 1:15 p.m. with executive director A and kitchen supervisor C regarding the kitchen observations referred to above revealed:
*The dessert bars were expected to have been covered until they were served to residents to protect them from potential contamination.
*"They [kitchen staff] know better" than to leave cups in the dry food storage containers and not to have used the designated ice machine scoop to fill beverage glasses.
-That was an infection control issue.
*Broth or gravy was expected to have been used to modify the food's texture and maintain its nutritional value.
*Hand hygiene was expected to have been performed and a new pair of gloves put on in between staff handling unclean and clean items in the kitchen.
*Kitchen supervisor C had noticed on 11/7/23 that the stand mixer had been dirty.
-She was working on having a more specific

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cleaning schedule for kitchen staff to follow in order to keep kitchen appliances clean.
*Regarding the salad bar executive director A and kitchen supervisor C expected:
-The Salad Bar Temp Log was completed prior to the salad bar cart having been taken to the dining room for meal service to decrease the liklihood of a food-borne illness occurring.
-Individual salad bar containers were covered until the cart was taken to the dining room for the meal service to decrease the liklihood of the food having been contaminated.
*There was no Salad Bar Cart policy so there had been no guidance for staff to have followed regarding cleaning and safely maintaining the salad bar cart.

Review of the revised 4/5/19 Sanitation policy revealed "7. All food must be covered while being stored or transported between areas in the food service department."

Review of the revised 4/15/14 Food Preparation and Handling policy revealed "5. Regular cleaning and sanitizing of equipment, utensils, and work surfaces will be performed."

Review of the revised 4/4/19 Food Service Cleaning and Sanitation policy revealed "3. Ice which is used in connection with food and drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner."

Review of the revised 4/5/19 Handwashing policy revealed "1. Hands will be washed:" "h. after handling dirty equipment, dishes, utensils, or taking out the garbage."

Refer to S506.

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S 503	Continued From page 23	S 503		
S 503	44:70:06:16 Person-in-charge of dietary services The person-in-charge of dietary services shall possess a current certificate from a ServSafe Food Protection Course, the Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association, or equivalent training determined by the department. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, and policy review, the provider failed to ensure the person in-charge of dietary services (kitchen supervisor C) had completed and possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 11/7/23 at 4:00 p.m. with kitchen supervisor C revealed: *She had been the kitchen supervisor since August 2023. *There were five kitchen employees including herself. -None of those employees had completed a ServSafe Food Protection course. *She was expected to but had not found the time to have completed a ServSafe Food Protection course. Interview on 11/8/23 with executive director A revealed: *She was responsible for but had not ensured kitchen supervisor C possessed the required qualifications associated with her job description. -That included the completion a ServSafe Food Protection course. Review of the revised 4/14/14 Dietary Service	S 503	S503: Supervisor C will complete ServSafe Food Protection Course Supervisor C will complete ServSafe Food Protection Course by 12/15/2023. Kitchen supervisor C will bring ServSafe completion certificate to monthly QA meeting.	12/23/2023

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S 503	Continued From page 24 Manager policy revealed "It is the policy of this facility that the Dietary service manager shall possess a current certification from a ServSafe Food Protection Course, the Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association, or equivalent training determined by the department."	S 503		
S 506	44:70:06:17 Required dietary inservice training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. The training shall be provided to any dietary or food-handling employee within 30 days of hire and annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of personnel files, EduCare on-line training documentation, dietary services training documentation, interview, and policy review, the provider failed to ensure required dietary inservice training was completed within 30 days of hire for three of three dietary staff (E, F, and H) and annually for one of one long term dietary staff person (G). Findings include: 1. Review of personnel files, EduCare on-line training documentation, and dietary services training documentation revealed: *Kitchen cook/server E was hired on 1/13/23. *Kitchen cook/server F was hired on 5/11/23.	S 506	S506: Kitchen Manager and/or RD will provide monthly inservice for all dietary employees. Executive Director will audit monthly x4. Executive Director will bring audits to monthly QA meeting. Kitchen cook/server F will complete ServSafe Food Protection Course. Kitchen Server H will complete Food Handler Certificate Course. Kitchen cook/server G will complete ServSafe Food Protection Course. Executive Director will work with registered dietitian to create a new orientation packet for dietary services. Orientation packet will be reviewed with all current employees at monthly meeting and all new employees upon hire. Executive Director will bring meeting attendance sheets to monthly QA meeting. Business Office Manager will audit all newly hired dietary employees for orientation packet completion weekly x 4 and monthly x 4. Business office manager will bring audits to monthly QA meeting. ServSafe and Food Handler Courses were started 12/4/2023 with a due date of 12/15/2023. New dietary training will include all required dietary courses as well as ServSafe training. Director of Nursing schedules all new hire training and annual training. Annual training is current at this time until August 2024.	12/23/2023

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S 506	Continued From page 25	S 506		

*Kitchen server H was hired on 1/23/23.
*There was no documentation to support dietary staff E, F, and H had completed the following required dietary training within 30 days of their hire: Food safety, handwashing, food handling/preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.

Interview on 11/7/23 at 11:30 a.m. with kitchen supervisor C regarding required dietary training for newly hired dietary staff revealed:
*There was no formal dietary training program for newly hired dietary staff when she assumed the kitchen supervisor position on 8/18/23.
-She had not developed a formal dietary training program for dietary staff since that time.
*She had tried to review dietary-related information with newly hired staff as her time allowed.
*She was responsible for ensuring newly hired dietary staff had been provided with required dietary training within 30 days of their hire date.

2. Review of personnel files, EduCare on-line training documentation, and dietary services training documentation revealed:
*Kitchen cook/server G was hired on 4/7/22.
*He had completed EduCare on-line training courses related to food safety, nutrition, and handwashing during the past year.
*There was no other dietary services training documentation to support he had received training related to: Food handling/preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling policies, time and temperature controls for food

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S 506	Continued From page 26 preparation and service, hydration, and sanitation requirements. Interview on 11/7/23 at 11:30 a.m. with kitchen supervisor C regarding the required ongoing dietary training for dietary staff revealed: *She provided dietary training on 9/15/23 which had covered several required dietary training topics. -Kitchen cook/server G had not attended that 9/15/23 training and there was no documentation to support kitchen supervisor C had reviewed the content from that training with kitchen cook/server G after the training had occurred. *It was her responsibility to ensure documentation had supported that an established schedule for ensuring dietary staff had received ongoing dietary training was in place. Review of the revised 4/11/14 Food Service In-Services policy revealed: *"It is the policy of this facility that new Dietary employees will be provided orientation. Dietary employees will be trained on meal serving and distribution procedures, food handling and preparation techniques, food safety, sanitation regulations, leftover food handling policies, hand washing, food-borne illnesses, time and temperature controls for food preparation and service, nutrition and hydration, and therapeutic diets." *"On-going monthly in-service training will be provided throughout the year."	S 506		
S 621	44:70:07:03 Medication therapy reviewed monthly The pharmacist shall report potential drug therapy irregularities and make recommendations	S 621	S621: Primary medical provider for resident 5 will be notified of pharmacy DRR. Primary medical provider for resident 10 will be notified of pharmacy DRR.	12/23/2023

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S 621	Continued From page 27 for improving the drug therapy of the resident to the resident's physician, physician assistant, or nurse practitioner, the facility's licensed nurse, and the administrator. The pharmacist shall document the review by preparing a monthly report of the potential irregularities and recommendations. The administrator shall retain the report in the assisted living center. This Administrative Rule of South Dakota is not met as evidenced by: Based on electronic care record review (ECR), interview, and policy review, the provider failed to ensure follow up by the medical provider for two of two sampled residents (5 and 10) monthly consulting pharmacist drug regimen review (DRR) recommendations two of twelve month reviewed. Findings include: 1. Review of resident 5's ECR revealed that on 5/19/23 and again on 6/20/23 the consulting pharmacist DRR had the following recommendation: *"1. Evaluate necessity of Symbicort. Started in February for persistent viral symptoms." *There was no documentation to support resident 5's primary medical provider had been notified of the pharmacist's recommendation. 2. Review of resident 10's ECR revealed that on 5/31/23 the consulting pharmacist DRR had the following recommendation: *"Dose reductions indicated or statement of contraindication for sertraline and quetiapine." *There was no documentation to support resident 5's primary medical provider had been notified of the pharmacist's recommendation. 3. Interview on 11/8/23 at 9:02 a.m. with director	S 621	S621 continued: Director of Nursing will meet with consulting pharmacy monthly x 4 to discuss missed DRRs and ways to stop this in the future. Director of Nursing will bring discussion topics to monthly QA meeting. Executive Director and Director of Nursing reviewed Drug Regimen Reviews Policy. Initial discussion with pharmacy to discuss missed DRRs occured on 11/29/2023. Director of Nursing is responsible to ensure follow up for all monthly DRRs. Director of nursing is reponsible to obtain provider response regarding monthly DRRs.. Executive Director will audit montly DRRs for provider alert and provider response x 4.	12/23/2023

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S 621	Continued From page 28 of nursing (DON) B regarding pharmacist drug regimen reviews for resident medications and physician notification revealed: *Their process was: -The consulting pharmacist documented in the resident ECR results of the DRR. -Thee pharmacist would then send a facsimile (fax) to DON B. -DON B would then notify the resident's primary medical provider of the pharmacist's recommendation and follow up with any changes that the provider determined was needed. *DON B confirmed the consulting pharmacist had documented the DRR's recommendations for resident 5 and resident 10 in the ECR's. *There was no documentation to support residents 5 and 10 had their primary medical provider notified of the pharmacist's recommendations. *DON B had not received a fax regarding the recommendations for residents 5 and 10. -She was not aware there had been pharmacist's recommendations made. 4. Review of the provider's 5/17/21 Drug Regimen Review policy revealed: *"The pharmaceutical provider for the community will do a drug regimen review (DRR) for each resident requiring community assistance with medication administration. -The minimum criteria for the DRR include, but are not limited to: --1. A diagnosis for each order --2. The drug regimen --3. Relevant lab findings --4. Dietary considerations --5. Evaluation for duplication of orders --6. Appropriate administration schedule for the resident -The DRR must include potential drug therapy	S 621		

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S 621	Continued From page 29 irregularities and have suggestions for improving drug therapy to the attending physician. The pharmacist must document the DRR, including irregularities and suggestions, in a monthly report which is retained by the facility."	S 621		
S 642	44:70:07:05 Control and accountability of medications Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on closed electronic care record (ECR) review, interview, and policy review, the provider failed to ensure one of one sampled discharged resident (9) had a physician order to send medications home with her upon discharge. Findings include: 1. Review of resident 9's closed ECR revealed: *She had been admitted on 6/7/23 *She had been discharged on 6/30/23. *A 6/30/23 progress note indicated the following medications had been sent with her: -Apixaban 5 mg 19 tablets. -Apixaban 5 mg 12 tablets. -Citalopram 20 mg 2 tablets. -Metoprolol 25 mg 13 tablets.	S 642	S642: Director of Nursing and Executive Director will update Release of Medications policy. Executive Director will audit resident discharges for discharge orders/medication orders weekly x 4 and monthly x 4. Executive Director will bring audits to monthly QA meeting. Director of Nursing will educate all UAP employees on Medication Administration policy. Director of Nursing will bring education certificates to monthly QA meeting. Director of Nursing will be responsible for order and documentation of of medications released. Executive Director will audit all resident disccharges for discharge orders/medications orders being received weekly x 4 and monthly x 4. Executive Director will bring audits to monthly QA meetings.	12/23/2023

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S 642	Continued From page 30	S 642		

-Trazadone 50 mg 10 tablets.
-Solifenacin 10 mg 3 tablets.
*There was no documentation to support a physician order had been obtained to send those medications home with her.

Interview on 11/8/23 at 10:00 a.m. with director of nursing B revealed:
*Their normal process was to send medications with a resident when they were discharged home.
*She would have been responsible for obtaining a physician order to send medications home with a resident on discharge.
*She had not obtained a physician's order to send medications with resident 9.
-She was unsure as to why she had not obtained a physician order.
*She confirmed resident 9's medications had been sent home with her when she was discharged.

Review of the provider's 4/15/15 Release of Medications policy revealed:
*"The facility will not dispense medications to residents upon discharge, transfer, or temporary leave from the facility. The Consultant Pharmacist is responsible for the dispensing of medications. Written authorization by the attending physician is required for the release of any medications to a resident upon discharge, transfer, or temporary leave from the facility."
*"Procedure:"
-"4. Medications are not to be sent out with residents for home use."

Interview and policy review on 11/8/23 at 3:12 p.m. with executive director A regarding release of medications when a resident was discharged home revealed:
*Medications were sent home with residents

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S 642	Continued From page 31 when they were discharged. -They did obtain a physician's order to send medications home with residents. -She confirmed there was no documentation to support a physician order to send medications home with resident 9 had been obtained. *She was not aware the policy included medications were not to have been sent with residents for home use.	S 642		
S 670	44:70:07:07 Medication administration A registered nurse shall provide medication administration training pursuant to §20:48:04.01 to any unlicensed assistive personnel employed by the facility who will be administering medications. Unlicensed assistive personnel shall receive initial and ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the facility. 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 one of five sampled unlicensed assistive personnel (UAP) (K) had received initial training in all aspects of medication administration. Findings include: 1. Review of UAP K's personnel record regarding medication administration training upon hire revealed: *UAP K was hired on 8/4/23. *She had received the initial medication administration training on the following topics:	S 670	S670: UAP K will have UAP competency completed. Business office manager will audit all newly hired UAPs for competency and training completion weekly x 4 and monthly x 4. Business office manager will bring audits to monthly QA meeting. Director of Nursing will complete all other annual UAP competencies in January 2024 when due. If a new UAP would be hired before this time a UAP competency would be completed upon hire. Director of nursing is responsible to UAP training and competency. EduCare is utilized for initial UAP training with UAP comptencies being completed upon hire and annually. Director of nursing is aware.	12/23/2023

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S 670	Continued From page 32 -On 9/4/23 oxygen administration. -On 10/9/23 blood glucose testing, catheter care, and insulin administration. -On 10/19/23 insulin pen administration. *She had not received any other medication administration training upon hire. Interview on 11/8/23 at 3:50 p.m. with director of nursing B regarding medication administration training for UAP K revealed: *She was responsible to ensure all personnel training was completed. *She confirmed UAP had not received the initial training in all aspects of medication administration. *She had not felt that any further training had been necessary to ensure UAP K was competent in medication administration as she already had a UAP certification. Review of the provider's 5/18/21 Personnel Training policy revealed: *"New employees will complete a general orientation session prior to training in their specific department." *"The on-going education program to be done annually will include, but is not limited to, the following topics:" -"10. Medication administration for UMA's [UAP's]. *The policy did not include initial medication administration training for UAP's.	S 670		
S 680	44:70:07:08 Medication records and administration Medication administration records must be used and regularly checked against the physician, physician assistant, or nurse practitioner's orders.	S 680	S680: Director of Nursing will review General Medication Administration Procedures with all UAPs during monthly mandatory meeting. Director of Nursing will bring attendance sheets and procedure hand out to monthly QA meeting. Director of Nursing will bring education certificates to monthly QA meeting.	12/23/2023

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S 680	Continued From page 33 Each medication administered must be recorded in the resident's medical record and signed by the individual responsible. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one unlicensed assistive personnel (UAP) (J) had not documented one of one observed resident's (5) medication had been administered prior to ensuring that medication had been taken. Findings include: 1. Observation and interview on 11/7/23 at 11:45 a.m. of UAP J during medication pass for resident 5 revealed she: *Mixed "4-8 oz [ounces] of cold water" as directed by the physician's order with the resident's potassium chloride solution in a plastic drinking cup. *Placed the resident's other five medications (all in tablet form) into a medication cup. -Entered the resident's room with the medications referred to above. *Had the resident take sips from the drinking cup referred to above in between swallowing each medication from the medication cup. *Encouraged the resident to drink the remainder of the drinking cup contents as she sat that cup on the kitchenette countertop prior to exiting the resident's room. *Documented on the electronic medication administration record the resident had been administered all of the medications referred to above when she had not confirmed the resident had consumed the potassium chloride solution inside of the drinking cup. *Agreed she should have waited to confirm	S 680	S680 continued Director of nursing will educate all newly hired/trained UAPs on General Medication Administration Procedures. Director of nursing will bring education certificates and hand outs to monthly QA x 4.	12/23/2023

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S 680	Continued From page 34 resident 5 had finished drinking the contents of the drinking cup prior to documenting she had administered that medication. Interview on 11/18/23 at 3:00 p.m. with director of nursing B regarding the observation referred to above revealed UAP J should have remained in resident 5's room to verify she had drunk the potassium chloride solution prior to leaving the room. Review of the revised 5/18/21 General Medication Administration Procedures revealed "10. Residents are observed for complete ingestion of the medication."	S 680		
S 681	44:70:07:08 Medication records and administration Medication errors and drug reactions must be reported to the resident's physician, physician assistant, or nurse practitioner and an entry made in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, review of the electronic medication administration record (E-MAR), and policy review, the provider failed to ensure the following: *One of one sampled resident (4) had received a physician ordered topical medication as prescribed. *A medication error for one of one sampled resident (4) had been identified and followed-up on. Findings include:	S 681	S681: Resident 4 has had all medications removed from his room and placed in the medication cart. Clotrimazole ointment has been discontinued, primary care provider notifed and pharmacy notified. Education provided to all UAPs on proper storage of medication. Policy to be reviewed at monthly nursing meeting. Attendance sheet will be brought to monthly QA meeting Director of Nursing to audit 1 random resident weekly x 4 and monthly x 4 for correct medication storage. Director of Nursing will bring audits to monthly QA meeting. Resident 4 has had cream medications discontinued. If resident 4 is prescribed a cream in the future and wishes to self-administer a self-administration assessment will be completed at that time. Director of Nursing will review self-administration policy with all UAPs at monthly nursing meeting. Director of Nursing will bring attendance sheet to monthly QA meeting. Director of Nursing will audit all new medication orders for accurace on all residents weekly x 4. Director of Nursing will then audit five random residents monthly x 4. Director of nursing will bring all audits to monthly QA meeting.	12/23/2023

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S 681	Continued From page 35 1. Observation, E-MAR review, and interview on 11/7/23 at 11:30 a.m. with unlicensed assistive personnel (UAP) J during medication administration for resident 4 revealed: *The resident had kept two physician-ordered topical ointments in his room that he self-administered. *The clotrimazole ointment was kept on his bedside table and the prescription label on it indicated the ointment was only to have been used "14 days" and discarded "after 7/6/23." *UAP J was not aware the prescription label on the ointment had identified an end date for its use and a discard date because the resident had self-administered the ointment. *There was no end date for the ointment identified on the resident's E-MAR. Interview on 11/8/23 at 3:00 p.m. with director of nursing B regarding the observation referred to above revealed: *She had entered the physician's order for use of resident 4's clotrimazole in to his E-MAR. *She had not included the physician's instruction to discontinue the ointment after 14 days resulting in: -The ointment not being discontinued after 14 days as ordered. -The ointment being used after the 7/6/23 discard date identified on the prescription label. -That was an unidentified medication error. Review of the revised 4/18/14 Medication Error policy revealed medication errors had included the "use of outdated or expired medication." Review of the revised 5/14/21 Bedside Storage of Medications policy revealed "5. Medications stored at the bedside are reordered in the same	S 681		

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S 681	Continued From page 36 manner as other medications. The nursing staff is responsible for the proper rotation of bedside stock and removal of expired medications."	S 681		
S 685	44:70:07:09 Self-administration of drugs A resident with the cognitive ability to understand may self-administer medications. At least every three months, the licensed nurse, the physician, physician assistant, or nurse practitioner shall evaluate and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or the nursing staff is responsible for storage of the drug and include documentation of its administration in accordance with the provisions of chapter 44:70:07. A resident may self-administer drugs if the registered nurse, if applicable, and physician, physician assistant, or nurse practitioner have determined the practice is safe. No resident may keep medications on the resident's person or in the resident's room without a medication order allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure one of one sampled resident (4): *Had been assessed to determine his ability to self-administer medications and to have been responsible for the storage of two of two observed physician-ordered medications. *Had a physician's order allowing him to self-administer two of two observed	S 685	S685: Resident 4 has had all medications removed from his apartment. Referring to S701 pertaining to resident refusals of this medication, an order has been received from resident primary care provider for medication to be discontinued. Director of nursing will provide education and policy review at monthly nursing meeting. Attendance sheet will be brought to monthly QA meeting. Director of Nursing will audit all self -administered medications for assessment completion and provder orders in chart. This will be done weekly x 4 and monthly x 4. Director of Nursing will bring all audits to monthly QA meeting.	12/23/2023

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	53872	A. BUILDING: ____ B. WING ____	C 11/08/2023

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S 685	Continued From page 37 physician-ordered medications. Findings include: 1. Observation and interview on 11/7/23 at 11:30 a.m. with unlicensed assistive personnel (UAP) J during medication administration for resident 4 revealed the resident: *Self-administered two physician-ordered medications and the UAPs administered all of his other medications. -Those two medications had included the Calmoseptine on his bathroom sink and the clotrimazole on his bedside table. Review of resident 4's care record revealed he had: *Not been assessed to determine his ability to self-administer or store his medications referred to above in his room. *No physician's order to self-administer those medications referred to above. Interview on 11/8/23 at 3:00 p.m. with director of nursing B regarding resident 4 revealed she: *Was unaware the resident had been self-administering the medications but the observation referred to above had supported the likelihood that he was. *Confirmed: -The resident had not been assessed for his ability to self-administer or store those physician-ordered medications in his room. -There was no physician order for resident 4 to self-administer those medications. *It was her responsibility to ensure the above expectations had been met prior to the resident having been allowed to self-administer medications. Review of the 4/18/14 Self-Administration of	S 685		12/23/2023

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S 685	Continued From page 38 Medications policy revealed: *"1. If the resident desires to self-administer medications, an assessment is conducted by the Registered Nurse of the Consultant Pharmacist to determine the safety of this practice." *"3. A Physician's order must be obtained for the resident to self-administer medications as well as to have bedside storage of medications."	S 685		
S 701	44:70:08:01 Record service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician assistant's, or nurse practitioner 's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident's physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, electronic medication administration record (E-MAR) review, care record review, and policy review, the provider failed to ensure one of one sampled resident's (4) care record documentation supported his repeated medication refusals had been identified and addressed. Findings include:	S 701	S701: Order has been received for resident 4 to have calmoseptine discontinued and to have clotrimazole discontinued. Lead UAP J will gather shift refusal forms to turn into Director of Nursing for review and provider alerts. Director of Nursing will bring these forms and results to monthly QA meeting x 4 months. UAPs on each shift will turn in shift refusal form to Director of Nursing at the end of each shift for review and provider alerts. Director of Nursing will bring these forms and results to monthly QA meeting x 4 months. Director of nursing will review shift refusal forms and send provider alerts to resident PCP as well as document in resident chart. Shift refusal forms as well as provider responses will be audited weekly x 4 and monthly x 4. Audits will be brought to monthly QA meeting. Policy on medication refusal will be reviewed with all UAPs at monthly meeting. Director of nursing will bring attendance sheet as well as receipt of copy to monthly QA meeting.	12/23/2023

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S 701	Continued From page 39	S 701		

1. Observation and interview on 11/7/23 at 11:30 a.m. with unlicensed assistive personnel (UAP) J during medication administration for resident 4 revealed:
*The resident self-administered two physician-ordered topical medications.
-The Calmoseptine was sitting on the bathroom sink in his room and the clotrimazole was sitting on his bedside table.

Interview on 11/8/23 at 8:50 a.m. with certified nurse aide (CNA)/UAP K regarding the self-administration of resident 4's medications referred to above revealed:
*The resident should not have self-administered or kept any physician-ordered medications in his room.
*His Calmoseptine and clotrimazole medications should have been kept in the medication cart.
-He usually had not allowed the UAPs to apply those medications.
*CNA/UAP K had not reported the resident's repeated topical medication application refusals to director of nursing (DON) B for follow-up with the resident's physician.

Review of resident 4's October 2023 and November 2023 electronic medication administration records (E-MAR) revealed he had refused:
*Calmoseptine 44 of 62 scheduled times in October and 12 of 15 scheduled times between 11/1/23 and 11/8/23.
*Clotrimazole 21 of 62 scheduled times in October and 11 of 15 scheduled times between 11/1/23 and 11/18/23.

Review of resident 4's care record revealed:
*There was documentation the resident's physician had been contacted multiple times

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S 701	Continued From page 40 between 10/1/23 and 11/8/23 regarding a new skin concern, pain follow-up, medication refill needs, and follow-up on the resident's edema. -The physician had not been notified regarding the residents refusal to have his prescribed topical medications applied. Interview on 11/8/23 at 3:00 p.m. with DON B regarding identification, notification, and follow-up of resident 4's topical medication refusals revealed she: *Had not been aware he had been not allowing UAPs to apply his physician-ordered medications. -It was the UAPs responsibility to have advised her of the resident's medication refusals so she could have notified the resident's physician, documented, and implemented that physician's response. Review of the revised 5/14/21 Medical Records policy revealed the resident care record was expected to have contained "6. Documentation that assures individual resident needs are identified and addressed."	S 701		
S1038	44:70:10:32 Emergency Electrical Service A facility with 16 beds or less shall be equipped with automatic emergency lighting for each exit way, staff work area, dining room, medication room, dietary department, room where main electrical panels are located, and power for the alarm system. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation, testing, and interview,	S1038	S1038: Electrician is scheduled for exit sign, with battery back up, installation. Emergency light on the second fllor (statement B) has been repaired. Electrician has visited and is currently preparing his price estimate so that installation may be scheduled. Emergency lights are on monthly checklist for maintenance manager P. Maintenance manager P will bring monthly checklist to QA monthly x 4.	12/23/2023

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S1038	Continued From page 41 the provider failed to install illuminated EXIT signs at six of six egress path locations. Findings include: 1. Observation on 11/7/23 beginning at 1:50 p.m. revealed the following egress paths on all three levels for the east and west wings (six locations) did not have EXIT signs showing the second path of egress for that wing on each floor. The EXIT signs must be provided with illumination having emergency power. Interview with the maintenance manager at the times of the observations confirmed those findings. B. Based on observation and interview, the provider failed to maintain one randomly observed emergency light on the second floor (Adjacent to room 215). Findings include: 1. Observation on 11/7/23 at 1:55 p.m. revealed the emergency light adjacent to room 215 did not have a light indicating power to the fixture. Testing of the emergency light at the time of the observation revealed it would not function. Interview with the maintenance manager (P) at the time of the observation confirmed that finding. Emergency lighting in accordance with Section 7.9 shall be provided in all buildings with more than 25 rooms, unless each sleeping room has a direct exit to the outside of the building at the finished ground level per NFPA 101, 2009 Edition, Section 32.3.2.9.	S1038		

South Dakota Department of Health

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{S 000}	Compliance Statement An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 1/10/24 for deficiencies cited on 11/8/23. All deficiencies have been corrected, and no new noncompliance was found. Pine Hills Retirement Community is in compliance with all regulations surveyed.	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE