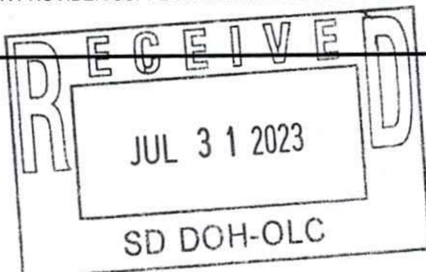
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11035	A. BUILDING: ______ B. WING ______	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN ASSISTED LIVING	**1321 COLUMBUS ST. RAPID CITY, SD 57701**

(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 complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 7/5/23. Area surveyed included nursing services. The Victorian Assisted Living was found not in compliance with the following requirements: S400, S415, and S681.	S 000		8/19/2023
S 400	44:70:05:01 Nursing policies and procedures The facility shall establish and maintain policies and procedures that provide the nursing staff with methods of meeting the facility's administrative and technical responsibilities in providing care to residents. The policies shall include at least the following: (1) The noting of diagnostic and therapeutic orders; (2) The assignment of the nursing care of residents; (3) Administration and control of medications; (4) Assessment and documentation by nursing personnel; (5) Infection control; (6) Resident safety; (7) Delineation of orders from nonphysician practitioners; and (8) Activities of daily living to maintain each resident's physical functioning, and personal care. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and job description review, the provider failed to ensure a policy or procedure had been developed for the use and expectations for completion of the	S 400	S400 1. Resident #1 unable to correct prior noncompliance 2. All residents have the potential to be affected by this deficiency 3. The DON/designee has accomplished training on medication administration and process education for medication errors to the clinical staff that administers medications. A medication error policy has been established and education has been provided by the DON/Designee to the clinical staff that administers medications. A review of current residents medication administration records has occurred by the DON/Designee to ensure accuracy. An audit of five residents' medication administration will be completed by the DON/designee weekly times 4 weeks, monthly times 3 and then monthly thereafter until substantial compliance is continually met. An audit of medication error reports will be completed by the DON/designee weekly times 4 weeks, monthly times 3 and then monthly thereafter until substantial compliance is continually met. 4. The results of these audits will be brought to the QA committee monthly for their review and advisement until continued substantial compliance is met for three consecutive months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Maciejewski
TITLE: Executive Director
(X6) DATE: 7/31/2023



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provider's Medication Error Report for one of one sampled resident (1) found to have had multiple medication errors occur within three of three sampled months reviewed (May-July 2023). Findings include:

1.a. Review of resident 1's 5/1/23 After Visit Summary revealed a physician's order to discontinue her irbesartan (blood pressure medication) on that date.

Review of resident 1's May 2023 Medication Administration Record (MAR) revealed:
*Documentation the irbesartan had been administered from 5/1/23 through 5/15/23.
*The irbesartan was administered after it had been discontinued and that should have been considered a medication error.

b. Review of resident 1's care record revealed a 5/31/23 physician order to "increase her clonidine patch (blood pressure medication) to 0.3 milligrams (mg) weekly. Put on an extra 0.1 mg clonidine today then go to clonidine patch 0.3 mg when next patch is due [6/4/23]."

Review of resident 1's June MAR revealed:
*On 6/4/23 at 7:00 a.m. both a 0.2 mg and a 0.3 mg clonidine patch had been documented as having been applied to the resident's skin.
-That dosage amount had exceeded the 0.3 mg dose that was ordered.
*Administration of a medication dose higher than what had been ordered by the physician should have been considered a medication error.

c. Review of resident 1's July 2023 MAR revealed:
*On 7/1/23 she was administered a "partial dosage" of the 300 mg gabapentin (nerve pain

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S 400	Continued From page 2 medication) that had been ordered by the physician. *From 7/2/23 through 7/4/23 gabapentin had not been administered to the resident. *Each occurrence when the gabapentin was not administered as ordered or had not been available for administration should have been considered a medication error. d. Interview on 7/5/23 at 3:00 p.m. with administrator A regarding resident 1 revealed: *She confirmed the findings referred to above were medication errors. *There was no policy or procedure for staff to follow regarding reporting medication errors that had occurred. *A Medication Error Report was expected to have been completed on those errors but copies of those reports had not been provided to the surveyor by the agreed upon time on 7/6/23. *There was no follow-up had occurred with those staff involved in making those medication errors and there was no documentation that resident 1's physician had been notified of those errors. Review of the undated Certified Medication Aide (UMA) job description revealed: "B.1. Administers and accurately records the administration of medications for residents as prescribed by the physician, or other primary care provider, in accordance with established state and federal regulations." Review of the undated RN/Med Trainer job description revealed her roles and responsibilities included: *"Supervise direct care staff ensuring that resident care and medication assistance is provided correctly and in accordance with policies and state regulations. Provide coaching and	S 400		

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S 400	Continued From page 3 training to care staff as needed under the direction of the Director of Nursing." Review of the undated Director of Nursing (DON) job description revealed: *"A. The DON is accountable to the facility Administrator and is responsible to oversee all resident cares and medical functions of [the assisted living facility], for the implementation of all medical policies and procedures, and to ensure all residents receive the highest level of services in accordance with State regulations." *"B. 13. Conducts audits of at least 10% of all charts weekly to verify proper charting and follow-up is being documented by staff nurses." Refer to S681.	S 400		
S 415	44:70:05:03 Resident care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental, and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) had appropriate nursing	S 415	S415 1. Resident#1- unable to correct prior noncompliance. 2. All residents have the potential to be affected by this deficient practice. 3. Care staff has been educated on proper treatment resident assessment, and documentation expectations by the DON/designee to include the status of a resident in general, a change of condition of a resident, the health status change of a resident that would require transport out to the acute care setting for evaluation, new medication orders and the reaction of the resident to the new medication orders. An audit of nursing documentation of five residents will be completed by the DON/Designee weekly times 4 weeks, monthly times 3 and then monthly thereafter until substantial compliance is continually met. 4. The results of these audits will be brought to the QA committee monthly for their review and advisement until continued substantial compliance is met for three consecutive months.	8/19/2023

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assessments and documentation related to her health conditions (hypertension and acute kidney injury) to ensure her individual care needs had been addressed. Findings include:

1.a. Review of resident 1's care record revealed:
*On 4/15/23 she had been found "slumped over in her chair in the dining room around 12:30 p.m. Resident was drooling, clammy & nonresponsive." Her vital signs were taken and she was weak and unsteady.
-Her blood pressure reading at that time was 93/44, pulse 73, respirations 16, and oxygen saturation 96%.
*She was transported to the local emergency department (ED) for evaluation.
*She had returned to the facility on 4/17/23 after hospitalization for treatment of an acute kidney injury and urinary tract infection (UTI).
*A 4/17/23 nurse progress note: "Resident returning from hospital. New med [medication] orders entered. Plan for f/u [follow-up] with PCP [primary care provider] in 1 week. Outpatient referral to Neurology. HH [home health] arranged by hospital. Daughter to transport home."
-There was no documentation regarding the resident's health condition or status to indicate the nurse had assessed her upon her return.
*A 4/17/23 unlicensed medication aide (UMA) progress note: "She is back in the facility."
*A 4/24/23 After Visit Summary (the hospital summary of the resident's hospital stay) had included instruction for care of the resident's buttock wound and orders for home health services.
*Review of the 4/18/23 through 4/24/23 UMA and nurse progress notes made no mention of how the resident had responded to medication changes that were made while she had been hospitalized, if she had any recurring signs or

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symptoms of a UTI, what the status of a buttock wound was, or if HH services had been initiated.
-The documentation had not included information to ensure the resident's needs had been addressed following her recent hospitalization.

b. Review of resident 1's care record revealed:
*A 4/28/23 progress note: "Admitted to hospital."
-There was no documentation regarding the resident's condition at that time or why she had required hospitalization.
*A 5/1/23 After Visit Summary revealed she had been hospitalized from 4/27/23 through 5/1/23 for treatment of an acute kidney injury.
*Review of the 5/1/23 through 5/8/23 UMA and nurse progress notes had no documentation of how the resident had responded to the medication changes made while she was hospitalized, the status of her skin condition, if HH services had been resumed, or how she had adjusted to being back in the facility.

c. Review of resident 1's care record revealed:
*On 5/29/23 she had been seen at the local ED for evaluation after a high blood pressure reading of 219/124 had been taken.
-She returned to the facility the same day.
*Registered nurse D documented there had been no new physician's orders and the resident was expected to follow-up with her physician in a few days.
-There was no documentation regarding the resident's health condition or status to indicate the nurse had assessed her upon her return.
*Review of the 5/29/23 through 6/2/23 UMA and nurse progress notes revealed there was no documentation in those notes if or how the resident had been monitored for new or recurrent signs or symptoms of high blood pressure.
*There was no documentation of any blood

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pressure readings after her ED return until 6/2/23.

d. Review of resident 1's care record revealed:
*On 6/3/23 at 5:33 p.m. UMA E documented he reported to RN D that the resident's blood pressure reading was 211/123.
-There was no documentation by UMA E related to RN D's response or instruction to him regarding that information.
*On 6/4/23 at 2:20 p.m. the resident had been seen in the local ED for evaluation of high blood pressure.
-She returned to the facility the same day.
*Review of the 6/3/23 through 6/9/23 UMA and nurse progress notes revealed there was no documentation if or how the resident had been monitored for new or recurrent signs or symptoms of high blood pressure.
*Blood pressure readings had been taken on 6/7/23 (157/95) and 6/8/23 (162/100).
-There was no documentation that information had been reported to or assessed by the RN.

e. Review of resident 1's care record revealed:
*On 6/14/23 UMA E documented he reported to RN D that the resident's blood pressure reading was 226/122.
-The resident was referred to the local ED for evaluation of high blood pressure and returned to the facility the same day.
*RN D had documented a change was made to the resident's blood pressure medication after that ED visit.
*Review of the 6/15/23 through 6/20/23 UMA and nurse progress notes revealed there was no documentation if or how the resident had been monitored for new or recurrent signs or symptoms of high blood pressure.

Interview on 7/5/23 at 3:15 p.m. with

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administrator A regarding resident 1 and the expectations for resident care record documentation revealed:
*She would have expected completion of a nursing assessment had been completed for any resident with a significant medical change like resident 1 had in the above findings.
-She confirmed the resident's most recent nursing assessment had been completed on 4/17/23.
*UMAs were expected to document pertinent resident observations (such as appetite, sleeping, appearance, mood, and speech) upon their return and in the days after their return from an ED visit or hospitalization.
-It was not within the UMAs scope of practice to have completed an assessment of the resident's condition.

Interview on 7/5/23 at 4:00 p.m. with UMA C regarding resident care record documentation revealed:
*UMAs were expected to document "everything" in the resident's record like medication changes, falls, and behavioral concerns as examples.
-If a resident had returned from the hospital, she would have documented a set of vital signs, how they had returned from the hospital, any new prescriptions, monitoring of any new signs and symptoms of the medical problem, and any other unusual changes.

Review of the undated Narrative Charting Entries policy revealed:
*4. Except in the cases of a new admission, fall or sentinel event, "staff utilize charting by exception related to resident status."
*"5. The administrator/designee reviews the narrative charting from the previous shift, for at risk residents."

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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 record review, interview, and policy review, the provider failed to ensure physician notification of medication errors had occurred for: *One of one sampled resident (1) who had been administered blood pressure medication for sixteen of sixteen days after it had been discontinued. *One of one sampled resident (1) who had not been administered nerve pain medication for three of three days due to not being available. *One of one sampled resident (1) who had been administered an incorrect dose of blood pressure medication for one of one day. *The process for noting and entering new physician orders into one of one sampled resident's (2) care record had occurred in a timely manner that ensured she had received her medication in a timely manner. Findings include: 1.a. Review of resident 1's 5/1/23 After Visit Summary revealed: *She had been hospitalized from 4/27/23 through 5/1/23. *Her 5/1/23 physician discharge orders had included an order to discontinue her irbesartan medication (used to treat high blood pressure).	S 681	S681 1.Resident#1and 2-unable to correct prior noncompliance. 2.All residents have the potential to be affected by this deficiency. 3. Licensed staff has been educated by the DON/designee on proper transcription of medication orders. Clinical staff have been educated on proper medication administration including obtaining medications as ordered by the physician timely from the pharmacy of resident preference, what to do if medications are not received timely and procedure for medication errors if they occur by the DON/designee. The Don/designee will audit physician orders daily the day after an order is received and/or on Mondays for weekend orders to ensure that medication changes are transcribed appropriately, discontinued medications have been discontinued and that medications are available. An audit of three medication administration events will be completed by the DON/Designee weekly times 4 weeks, monthly times 3 and then monthly thereafter until substantial compliance is continually met. An audit of three MARs to monitor for availability of medications and proper administration will be completed by the DON/designee weekly times 4 weeks, monthly times 3 and then monthly thereafter until substantial compliance is continually met. 4.The results of these audits will be brought to the QA committee monthly for their review and advisement until continued substantial compliance is met for three consecutive months	8/19/2023

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Review of resident 1's May 2023 Medication Administration Record (MAR) revealed:
*Irbesartan was still listed as an active medication on the MAR.
-There was documention of the administration of that medication from 5/1/23 through 5/15/23 even though it had been discontinued on 5/1/23.

Review of resident 1's care record revealed there was no documentation her physician had been notified of that medication error or that she had been getting the irbesartan after it was ordered to have been discontinued.

b. Review of resident 1's care record revealed a 6/1/23 electronically transmitted prescription for gabapentin: (used for nerve pain) 300 milligrams (mg), two capsules daily at night.

Review of resident 1's July 2023 MAR revealed:
*She had been administered a "partial dose" of the 300 mg ordered gabapentin dose on 7/1/23.
*Gabapentin had not been available to administer on 7/2/23, 7/3/23, or 7/4/23.

Review of resident 1's care record revealed there was no documentation her physician had been notified of that medication error or that she had not been administered that gabapentin as ordered.

Interview on 7/5/23 at 1:20 p.m. with unlicensed medication aide (UMA) C revealed:
*An unidentified night shift UMA had notified her the morning of 7/2/23 that resident 1 had no more remaining doses of her gabapentin.
*UMA C faxed a Medication Reorder Sheet to the pharmacy provider on 7/2/23 at 8:45 a.m. requesting a refill of that medication.
*The pharmacy provider usually had filled those

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reorder requests within 24 hours.
*UMA C was unaware resident 1's medication reorder request had not been filled by the pharmacy provider and the resident had not received her gabapentin as ordered since 7/1/23.
-She usually worked the day shift and the gabapentin was ordered to have been administered on the evening shift.

Interview on 7/5/23 at 2:00 p.m. with administrator A and administrative assistant B regarding medication reordering revealed:
*On 7/3/23 the pharmacy provider delivered the medication refills that had been requested on the 7/2/23 Medication Reorder Sheet referred to above.
-A print-out that listed all the medications that had been delivered to the facility by the pharmacy on 7/3/23 had not included resident 1's gabapentin.
*It was expected staff who had received refilled medications from the pharmacy had reconciled the 7/2/23 Medication Reorder Sheet against the list of reordered medications the pharmacy provider had delivered on 7/3/23.
-That had not occurred.
*The resident not having been administered her medication as ordered was a medication error.
-The resident's physician should have been notified of that error and that medication error should have been documented in the resident's care record.

Review of the undated Medication Refills policy revealed:
*"1. The designated staff person contacts the dispensing pharmacy to obtain a refill at least seven (7) days prior to running out of a medication, unless medication is on a cycle refill with the pharmacy."
*" 3. Medications are never allowed to run out

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unless directed to by the physician (obtain this direction in writing)."

c. Review of a 5/31/23 physician signed medication order change for resident 1 revealed:
*"Increase clonidine patch (used to treat high blood pressure) to 0.3 mg weekly. Put on an extra 0.1 mg clonidine today then go to clonidine patch 0.3 mg when next patch due."
-That due date was 6/4/23.

Review of resident 1's June 2023 MAR revealed:
*There had been two separate physician orders for the clonidine patch: one for 0.2 mg and one for 0.3 mg.
*On 6/4/23 at 7:00 a.m. both a 0.2 mg and a 0.3 mg patch had been documented as having been applied to the resident's skin.
-That dose was 0.2 mg more than the physician had ordered the resident to have received.

Review of resident 1's care record revealed there was no documentation her physician had been notified of that medication error or that she had been administered an incorrect dosage of clonidine than what had been physician ordered.

d. Interview on 7/5/23 at 3:00 p.m. with administrator A regarding the findings referred to above for resident 1 revealed:
*The findings above were considered medication errors.
*She had noted and entered the medication change order on the MAR for the discontinuation of the irbesartan on 5/15/23.
-That had occurred 16 days after the physician order had been received.
-That medication change order should have been noted and entered on the MAR on the date it had been received on 5/1/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11035	A. BUILDING: ____ B. WING ____	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN ASSISTED LIVING	1321 COLUMBUS ST. RAPID CITY, SD 57701

(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 681	Continued From page 12 *She had noted and entered the 0.3 clonidine medication change order on the MAR for the clonidine patch dosage change on 5/31/23. -The 0.2 mg clonidine order that was already on the MAR should have been discontinued at that same time to ensure the correct dose of medication was administered to the resident. Refer to S400. 2. Review of resident 2's care record revealed she: *Was sent to the Emergency Department (ED) on 4/26/23. -Admitted on 4/27/23 to have her gallbladder removed. *Returned to the facility on 6/22/23 with a discharge summary that included the following: -The resident received extended intravenous antibiotics for a spinal infection. -The follow up appointment with the neurosurgeon was scheduled on 6/27/23. *She had gone to her neurology appointment and the neurosurgeon sent her to the ED for incontinence of the bowel, vomiting and low blood pressure. *The resident returned to the facility on 6/27/23 with new orders from ED physician for: -"Ondansetron-ODT (Zofran-ODT) 4 mg disintegrating tablet. --Take 1 tablet (4 mg total) by mouth every 8 (eight) hours as needed for nausea or vomiting for up to 7 days. -Loperamide (IMODIUM) 2 mg capsule. --Take 1 capsule (2 mg total) by mouth 4 (four) times a day as needed for diarrhea for up to 10 days." Review of resident 2's June and July Medication Administration Records (MAR's) were not	S 681		

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S 681	Continued From page 13	S 681		

updated to reflect the addition of the new medication orders she received from the ED physician on 6/27/23.

Interview on 7/5/23 at 12:33 p.m. with resident 2 revealed she:
*Was throwing up, nauseous and having diarrhea when she was at her neurosurgery appointment.
*Was told by the nurses and her neurosurgeon that she needed to go to the ED.
*Had returned to the facility from the ED later that day.
*Continued to have diarrhea and nausea for up to three days after her return to the facility from the ED.
-She had taken one loperamide (IMODIUM) in those three days.
-Thought she had taken one ondansetron-ODT (Zofran-ODT) but could not recall the day.

Interview on 7/5/23 at 12:50 p.m. with UMA C regarding resident 2's medications revealed she:
*Confirmed the physician orders for the medications were scanned into the resident's care record.
*Had not found the medication orders on the MAR.
*Found the unopened medications in the medication cart behind the residents' other medications.
-The delivered date on the medications was 6/28/23.
*Stated when the medications were brought in, they were to have been entered into the MAR by the nurse.
*Was on duty the day the resident received one loperamide (IMODIUM) from her sister after returning to the facility from the ED.

Interview on 7/5/23 at 3:45 p.m. with

South Dakota Department of Health

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S 681	Continued From page 14	S 681		

administrator A and administrative assistant B regarding resident 2's medications revealed:
*They knew the resident returned on 6/27/23 from the ED.
*They were told the sister had the physcian order and was going to bring it to the facility in a couple days.
*They were not aware that the physician ordered medications were delivered on 6/28/23.
*A licensed nurse was the one that entered the medication orders into the MAR.
-When a medication delivery comes to the facility the person that receiveed those medications was to have checked the MAR to ensure there was a physician order and it was correct. If any discrepancy was found, they were to have notified administrator A, she was the only nurse.
--Administrator A was not informed of the medication delivery.

Continued review of resident 2's care record revealed that there had not been any documentation that the physician was notified of the medication error.

Review of the providers undated Medication Management Policy revealed:
*" When a resident arrives at the community with a new medication, steps will be taken to ensure proper storage and handling of the medication. Physician's orders will be verified for all medications."
-"5. The medications are appropriately listed on the MAR, verifying accuracy according to the physician orders."

A Medication Order Entry policy was requested from administrative assistant B on 7/5/23 at 1:45 p.m. but no policy was provided. The staff were referred to an undated Resident Arrives with a

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S 681	Continued From page 15 Medication policy which had not addressed the process for receiving, verifying, and entering physician orders.	S 681		8/19/2023