STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41332	A. BUILDING: _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF SISSETON LLC	308 HILLVIEW RD SISSETON, SD 57262

(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 3/26/24 through 3/28/24. Edgewood Greenleaf Sisseton LLC was found not in compliance with the following requirement: S200 and S337. 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 3/26/24 through 3/28/24. The area surveyed was resident neglect related to an elopement. Edgewood Greenleaf Sisseton LLC was found not in compliance with the following requirement: S169.	S 000		05/12/2024
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) event report review, observation, interview, testing, and policy review the provider failed to maintain an electrically activated audible alarm on one of five exit doors (main entrance) when it switched over to nighttime monitoring.	S 169	1. Red White with United Technologies was here on 4/5/24 and provided maintenance to the front door alarm system. Alarm is now working properly. 2. Door alarm policy was updated by Executive Director. All staff meeting held on 4/10/2024 and education given by Executive Director on how to activate night door alarm and the importance of making sure it is activated as well as proper documentation of checking door alarm. Chore added to PM CMA chore list in Rtasks to set night time alarm. The chore will have to be signed off in Rtasks by PM CMA. Night time alarm monitoring was also added to day time preventative maintenance as well, which is done weekly and added into TELS, our preventative maintenance check off. Door alarm policy will be added into new hire orientation and will be reviewed annualy with all staff. 3. Sign off for activating and checking the night time alarm on front door as well as the weekly preventitive maintenance will be audited by Executive Director or designee weekly x4; bi-weekly x2; and monthly x 1. Results will be reviewed at the monthly Quality Meeting to determine complaince.	~~07/24/2024~~

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Veranda Shindelbower — TITLE: Executive Director/RN — (X6) DATE: ~~04/19/2024~~

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S 169	Continued From page 1 Findings include: 1. Review of the provider's SD DOH event report for resident 2 indicated on 1/1/24 resident 2 had eloped from the building. *At 9:00 p.m. a neighbor of the provider returned resident 2 to the facility. *Resident 2 had left the building and staff were unaware. *She had fallen in the neighbor's backyard. *A fall assessment and neuro checks were completedafter the resident returned to the facility. *Her daughter, physician and executive director (ED) A were notified. Observation and interview on 3/27/24 at 5:10 p.m. with certified medication aide (CMA) D regarding resident 2's presence near the front door revealed: *Resident 2 was frequently pacing in and out of the front entrance area. -She would stop and stare out the front door for a few minutes. -She asked CMA D if her daughter was coming today. -CMA D told resident 2 she was not sure if her daughter would come to visit. *CMA D stated the staff monitored resident 2 and tried to keep her distracted because she had high anxiety. *CMA D confirmed the front door would make a sound like a doorbell when someone entered or exited the building. *The doorbell only sounded once and then would shut off once the door closed. Interview and front door alarm testing on 3/28/24 at 10:45 a.m. with ED A revealed: *The night shift staff were responsible for	S 169		

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S 169	Continued From page 2 switching the front door alarm to night mode at 10:00 p.m. *A code had to be entered at the front door to switch the alarm from daytime monitoring to nighttime monitoring. *Visitors would have to enter a code to access the building after it was switched to the nighttime monitoring. *ED A attempted to change the code several times to demonstrate the process. -The door alarm did not transfer properly to the nighttime mode. -ED A had maintenance supervisor C attempt to have the alarm switch to night mode. -Maintenance supervisor C was unsuccessful getting the door alarm to work properly. *ED A stated no one from the night shift had notified her that it was not working. *ED A confirmed the facility did not have the monitoring of the nighttime front door alarm as part of the preventive maintenance plan. Review of the provider's undated Door Code Policy and Utilization revealed: *"The community strives to promote resident safety through the alarmed door system. The alarmed doors assure that staff are aware when someone leaves/enters the building. Residents are provided additional security and safety as staff are aware if the resident were to leave the building via an alarmed door."	S 169		
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of	S 200		

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S 200	Continued From page 3 greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, and interview, the provider failed to maintain compliance with fire safety requirements required by the Life Safety Code, NFPA 101 (fire door latching, smoke detection system maintenance, and third-shift fire drills). Findings include: 1. Observation on 3/27/24 at 10:15 a.m. revealed the south cross-corridor fire door leading to the south (new addition) wing did not latch at the top latch. Further trials of the door revealed the crash bar was sticking. Further inspection of the door revealed the 90-minute door was only supplied with one latch point rather than the two required latches. Maintenance supervisor C was present and acknowledged the latching difficulties with the door at the time of the observation. 2. Record review and interview with assistant executive director B on 3/27/24 from 11:15 a.m. through 11:45 a.m. revealed excellent documentation of monthly fire drills, but no documentation of any third shift, or overnight drills. Assistant executive director B acknowledged that the overnight drills were not being completed. 3. Record review on 3/27/24 at 11:30 a.m. revealed the last maintenance for the smoke detection system was performed on 7/7/22. The	S 200	1. Fire pin has been purchased and will be installed by 4/15/2024. Which will give the fire door the required two latch points. Top latch was maintenanced on 4/5/2024 and is working properly. The crash bar was lubricated on 4/4/2024 and is working properly. Weekly inspection of the fire doors are done and documented in TELS. Executive Director or designees will audit fire door documentation weekly x4; bi-weekly x2 and monthly x1. Audits will be discussed at the monthly Quality meeting to determine complinace. 2. All staff meeting held on 4/10/2024. Education provided by Executive Director on the importance of conducting third shirt fire drills. Education given by Executive Director on how to conduct a fire drill. Fire drill was completed after the all staff meeting. Executive Director or designess will audit fire drills for third shift quarterly X 4 as shift 3 fire drills are scheduled once a quarter. Audits will be reviewed at the monthly Quality Meeting to determine complaince. 3. ABC fire contacted. Inspection will be conducted on 4/23/2024. Executive Director or designee will audit ABC fire inspections quarterly x 1 year Audits will be reviewed at montly Quality Meetings to determine complinace.	05/12/2024 ~~7/24/2024~~ ~~07/24/2024~~ ~~05/24/2025~~

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S 200	Continued From page 4 system was required to be maintained annually, and thus, did not comply with the requirements. Interview with the executive director A on 3/27/24 at 1:30 p.m. revealed she had noted the noncompliance when she found the system records and said she would get the contractor scheduled to perform the required maintenance.	S 200		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, manufacturer's instructions, and policy review, the provider failed to ensure two of two certified medication aides (CMAs) (D and E) correctly instructed two of two sampled residents (3 and 5) to prime the insulin pen prior to administration. Finding include: 1. Observation and interview on 3/27/24 at 11:37 a.m. with CMA E in resident 5's room revealed: *Resident 5 had a physician's order for Lispro 8 units Sub-Q (subcutaneous) before the noon and evening meals. *CMA E placed the needle on the insulin pen and handed it to resident 5 with an alcohol prep wipe. -She instructed resident 5 to wipe his abdomen before administering the insulin. -She instructed resident 5 to turn the dial on the pen to eight units. -She verified the correct dose and had resident 5	S 337	1. All staff meeting held on 4/10/24. CMAs were educated by Executive Director/RN on insulin administration polity. CMAs performed demonstration on assisting residents to administer insulin via pen primed with 2 units per policy. Executive Director or designess will audit insulin administration weekly x3; bi-weekly x2 and monthly x1. Audits will be reviewed at the monthly Quality Meeting to determine complaince.	05/12/2024 ~~7/24/2024~~

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S 337	Continued From page 5 inject the insulin. -She did not have the resident prime the insulin pen before dialing the correct dosage. *When asked about having resident 5 prime the insulin pen before administration CMA E stated she had never heard of that. *CMA E stated she had been a medication aide for 17 years. 2a. Observation and interview on 3/27/24 at 4:58 p.m. with CMA D in resident 5's room revealed: *Resident 5 had a physician's order for Lispro 8 units Sub-Q before the noon and evening meals. *CMA D placed the needle on the insulin pen and handed it to resident 5 with an alcohol prep wipe. -She instructed resident 5 to wipe his abdomen before administering the insulin. -She instructed resident 5 to turn the dial on the pen to eight units. -She verified the correct dose and had resident 5 inject the insulin. -She did not have the resident prime the insulin pen before dialing the correct dosage. 2b. Observation and interview on 3/27/24 at 5:03 pm with CMA D in resident 3s room revealed: *Resident 3 had a physician's order for Lantus 50 units BID (twice daily). *CMA D placed the needle on the insulin pen and handed it to resident 3 with an alcohol prep wipe. -She instructed resident 3 to wipe his abdomen before administering the insulin. -She instructed resident 3 to turn the dial on the pen to 50 units. -She verified the correct dose and had resident 5 inject the insulin. -She did not have the resident prime the insulin pen before dialing the correct dosage. *When asked about having residents prime the	S 337		

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S 337	Continued From page 6 insulin pen before administration CMA D stated, "That would make sense since her grandpa used to get insulin from a bottle, and he would make sure the bubbles were out of the syringe before he gave himself his insulin". Review of the manufacturer's instructions for Insulin Lispro Injection KwikPen revealed: *"Prime before each injection. *Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. *If you do not prime before each injection, you may get too much or too little insulin." Review of the manufacturer's instructions for Lantus Solostar prefilled pen revealed: *"Step 3: Do a safety test. -Always do a safety test before each injection to: --Check your pen and the needle to make sure they are working properly. --Make sure that you get the correct Lantus dose. *3A select 2 units by turning the dose selector until the dose pointer is at the 2 mark. *3B Press the injection button all the way in. -When insulin comes out of the needle tip, your pen is working correctly. -If no insulin appears: --You may need to repeat this step up to 3times before seeing insulin. --If no insulin comes out after the third time, the needle may be blocked." Interview on 3/28/24 at 9:55 a.m. with executive director A regarding resident insulin administration revealed: *Staff were not trained as diabetic aides. *Staff were only supposed to talk the residents through the insulin administration process.	S 337		

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S 337	Continued From page 7 *Her expectation was residents would administer the correct dose of insulin. *Staff should have had the residents prime the insulin pens to ensure they were working properly. *She agreed the instructions for the insulin pens were not followed. Review of the provider's March 2024 Insulin Pen Policy revealed: *"All clinical staff will be educated on insulin pen administration prior to administering insulin. *All medication aides will have Insulin Administration by Pen Competency completed by a Registered Nurse."	S 337		

South Dakota Department of Health

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{S 000}	Compliance Statement A 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 5/17/24, for all previous deficiencies cited on 3/28/24. All deficiencies have been corrected, and no new noncompliance was found. Edgewood Greenleaf Sisseton LLC was found in compliance with all regulations surveyed.	{S 000}		

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