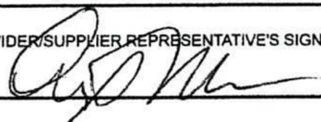
South Dakota Department of Health

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 02/05/2026

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 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 2/3/26 through 2/5/26. The Victorian Assisted Living was found not in compliance with the following requirements: S096, S130, S201, S315, S320, S331, S337, S352, S485, S603, S630, S632, S680, S775, and S791. 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 2/3/26 through 2/5/26. Areas surveyed included resident neglect, physical environment, and infection control. The Victorian Assisted Living was found in compliance.	S 000		
S 096	44:70:02:05 Housekeeping Cleaning Methods And Equipment Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy	S 096		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE Executive Director (X6) DATE 3-5-26

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S 096	Continued From page 1 review, the provider failed to ensure one of two sampled laundry rooms with chemical storage was inaccessible to residents. Findings include: 1. Observation on 2/4/26 at 10:28 a.m. revealed: *The main laundry room was next to the resident's dining room. *There was a sign on the door that read "door to remain locked at all times." *The door to the main laundry room was unlocked. There were multiple buckets of industrial dishwashing chemical on the floor. 2. Further observation on 2/4/26 at 4:35 p.m. revealed that the main laundry room was still unlocked and those same chemicals were still on the floor and on the table. 3. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed: *They stated that it was not normal practice for the main laundry door to be unlocked. All staff members knew the door code and had access to that room. *They acknowledged that residents would have access to several types of chemicals in the main laundry if this door was not locked. 4. A chemical storage policy was requested from the provider on 2/5/26 at 11:00 a.m. and the provider was unable to provide a policy.	S 096	The ED or Administrative Assistant will check the laundry room door daily, every day for the month of March. An audit form will be used to sign off if it was locked. Then the door will be checked weekly for three months, ending 7/31/26. An audit form will be used for this also. Staff was educated on 3/4/26 about the importance of making sure the laundry room door is locked due to the storage of chemicals and being a safety concern for the residents. The audits will be done at various times and different shifts. The times will be documented. This audit will be discussed at QA meetings for input and recommendations.	3/22/26
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions	S 130		

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S 130	Continued From page 2 as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure that an infection prevention and control program was in place. Findings include: 1. Interview on 2/5/26 at 10:05 a.m. with administrative assistant B revealed: *The infection prevention and control program information was kept in a binder at the nurse's station. 2. Review of the provider's infection control binder revealed: *Monthly monitoring sheets that included topics such as the resident who was being monitored, their room number, the date of the monitoring, the resident's current infection, and testing information [such as labs or bacterial culture results]. The monitoring sheet also included the antibiotic that the resident was on including the dose, duration, and predicted stop date. *The monthly monitoring sheets were separated by month and had the twelve months for 2025. The binder did not include any monitoring sheets for the year 2026.	S 130	An Infection Prevention and Control program was implemented on 2/13/26. The Administrative Assistant was provided with education from the corporate clinical director regarding the infection control program and implementing it. An audit sheet was created to track the infection program. There is a weekly audit for six weeks, then monthly until compliance is met for three months, ending 7/31/26. The new DON started 2/23/26. She is involved in the program and will be involved in the audits and meetings. ***The Clinical director provided training for our new DON on 3/6/26 about infection prevention and control program.*** ***The clinical Director will be meeting with the DON once a month regarding infection prevention and control program.*** ***The Clinical Director will meet monthly with the DON for six months, ending 7/30/26.*** ***Tracking infection control with McGEERS, tracking type of infection, trends, mapping, labs, treatments and symptoms with dates.*** ***Infection control program will be reviewed at QA for input and recommendations.***	3/22/26

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S 130	Continued From page 3	S 130		

-The binder had two completed logs in March 2025 for two different residents that were currently on antibiotic medications.
*The rest of the binder was empty.

3. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed:
*The director of nursing (DON) or registered nurse (RN) was responsible for the infection control and prevention plan. They did not have a current DON. The previous DON's last worked shift was on 12/19/25, and that DON was now an as-needed employee. They did not have another RN working at the facility.
*They agreed that they were not monitoring infection symptoms of the residents or antibiotic use.
*They stated that they were aware of state regulations for an assisted living facility to have a healthcare staff member be responsible for the program, including monitoring and reporting activities.
*The infection monitoring and prevention information was not reported to the quality assurance and performance improvement (QAPI) team when they met monthly.
*There was a recent outbreak of COVID-19 in the facility last month (January 2026). The residents' symptoms or medications related to the infection were not monitored by a nurse.

4. Review of the providers' DON job description revealed:
*The DON was responsible to "directly reports to the facility executive director on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations."

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S 130	Continued From page 4 *The DON was also to "complete the required assessments in a timely manner, on each resident" and to "ensure personal and medical data is entered into the electronic medical record of each resident in the facility."	S 130		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview the provider failed to continuously maintain an egress free of obstructions that would prevent its use to a public way for three of eight observed facility exit doors (North hallway, south hallway, and east hallway exits). Findings include: 1. Observation on 2/3/2026 at 12:30 p.m. with maintenance E in the south hallway revealed that one hallway exit door at the south end which opened to a sidewalk, did not provide access to the nearby cul-de-sac (public way) only several feet further away from the facility to the south. The existing sidewalk led to a locked courtyard gate in one direction and a circuitous route around (and close to) the entire western half of	S 201	Maintenance will receive three estimates for a sidewalk to the cul-de-sac by 3/31/26. Maintenance will also contact the city for approval for the placement of the sidewalk by 3/31/26. *After estimates and city approval are received, maintenance will ensure completion of the sidewalk. The sidewalk progress will be reviewed at QA for input and recommendations.*	3/22/26

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S 201	Continued From page 5 the facility in the other direction to reach a different public way (delivery driveway). The sidewalk also did not have a sign indicating an egress direction. The existing sidewalk would have created confusion as to where those who may have required use of that exit door should proceed to move away from the building via a public way. The nearby cul-de-sac could be easily seen from the exit door, but had no maintained surface leading to it. 2. Observation on 2/3/2026 at 1:15 p.m. with maintenance E in the east hallway revealed that one hallway exit door at the east end which opened to an elevated wooden deck was "permanently closed" by a wooden blockade that was on the stairs. Those stairs connected the deck to the nearby parking lot (public way). The blockade eliminated the ability of those who may have required the use of that exit door to move away from the building via a public way. 3. Observation on 2/3/2026 at 2:10 p.m. with maintenance E in the north hallway revealed that one hallway exit door at the north end opened to an elevated wooden deck with stairs near both the northeast and northwest corners of the building were "permanently closed" by wooden blockades. The stairs connected the deck to the nearby parking lot (public way) near the northeast building corner and a delivery driveway (public way) near the northwest building corner. The blockades eliminated the ability of those who may have required use of that exit door to move away from the building via a public way. Interview with maintenance E on 2/3/2026 at the time of the observations confirmed those findings.	S 201	Exit this way signs have been placed on the decks and sidewalk. Maintenance will have the wooden blockades removed by 4/1/26. Two emergency evacuation stair chairs were ordered on 3/4/26. Once the chairs arrive, the ED will provide staff with education on how to use the stair chairs by 4/1/26. All staff will sign off on the education by 4/15/26. New staff will receive the chair education during on boarding, the signed education will be placed in their file. The education will be provided to all staff quarterly, signed form will be placed in their file.	3/22/26

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S 315	Continued From page 6	S 315		
S 315	44:70:04:07 Prevention And Control Of Influenza Each facility shall arrange for an influenza vaccination to be completed annually for each resident. Each resident shall be offered influenza vaccine when the resident is admitted and annually during the influenza season. Documentation of the vaccination or refusal must be recorded 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 document an influenza vaccination or its refusal for one of three sampled residents (8) upon admission to the facility. Findings include: 1. Review of resident 8's care record revealed: *He was admitted to the facility on 1/15/26. *There was no documentation that he was given an influenza vaccination, or if he had refused it upon admission to the facility. 2. Interview on 2/4/26 at 8:20 a.m. with administrative assistant B revealed: *She stated that resident 8's influenza vaccination or his refusal should have been completed upon his admission to the facility. *She stated that it was a nurse's responsibility to complete, and acknowledged that they did not have a Director of Nursing (DON) or a licensed nurse on staff. The as-needed nurse had not worked a shift since 12/19/25. *She acknowledged there was no documentation for the influenza vaccination or refusal in resident 8's care record.	S 315	The administrative assistant created a form for all new residents, including influenza vaccine, COVID v vaccine, RSV vaccine, Pneumonia vaccine, Tdap vaccine and the shingles vaccine. All new residents, upon admission will check either refuse or accept for all vaccines. The administrative assistant has added all historical vaccines into PCC on our current residents. The immunization checklist and TB1 and TB2 are on the audit sheet, that will be completed for every admission. The audit sheet for new admits will be used for six months, ending 9/30/26. This audit will be completed by the ED and administrative assistant. *Resident 8 will be offered the flu vaccine 3/12/26. All immunization sheets have been inputed and refusals have been received. All residents were audited for flu vaccines on 3/ 5/26. All residents that wanted the flu vaccine received it. The immunization accept or refusal form will be completed upon admission by the ED. Resident 8 was offered the flu vaccine on 3/12/26. He wants to discuss with his provider first due to his dx.*	3/22/26

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S 315	Continued From page 7 3. Review of the provider's undated Influenza/Pneumonia Vaccine policy revealed: *"When possible, the Community [provider] will arrange for annual onsite flu vaccines for residents and staff through an outside provider." *"All residents and employees who have direct contact with residents will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza." *"A resident's refusal of the vaccine shall be documented in the resident's medical record." *"Documentation of previous vaccination should be provided to the Community [provider]." 4. Review of the providers' undated Resident's Rights And Services Handbook revealed: *"Pneumococcal vaccinations and annual influenza vaccinations are strongly encouraged for all residents." *"The county health nurse, home health nurse, or facility nurse may offer the vaccine to residents wishing to participate. However, the vaccines may be waived for a resident because of religious beliefs, medical contraindication, or refusal by the resident." *"Documentation of the vaccination or its waiver must be recorded in the "Staff Notes" section of the resident chart." 5. Review of the providers' Director of Nursing (DON) job description revealed: *The DON reports directly to the facility executive director on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations." *The DON was also to "complete the required assessments in a timely manner, on each	S 315	*If the new resident checks chooses accept for a vaccine, the DON will request an order, send to pharmacy and the nurse will administer. If the resident chooses to refuse, the nurse will provide education and document in a progress note.* *The vaccine audit form will be done on every new admission.* *Flu audits will be reviewed at QA for input and recommendations.* All employees will be offered the influenza vaccine at future flu clinics. Their refusal or acceptance will be documented and placed in their employee file.	

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S 315	Continued From page 8 resident" and to "ensure personal and medical data is entered into the electronic medical record of each resident in the facility."	S 315		
S 320	44:70:08 Prevention And Control Of Pneumonia Each facility shall arrange for an immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage a resident to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded 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 document resident pneumonia vaccinations or refusals for four of eight sampled residents (1, 5, 8, and 11) within fourteen days of their admission to the facility. Findings include: 1. Review of resident 8's care record revealed: *He was admitted to the facility on 1/15/26. *There was no documentation of his pneumonia vaccinations or his refusals within 14 days of his admission to the facility. 2. Review of residents 1, 5, and 11's care records revealed: *Resident 1 was admitted on 12/8/23, resident 5 was admitted on 1/26/26, and resident 11 was admitted on 1/6/26 to the facility. *None of the above residents had a documented administration, acceptance, or refusal of the	S 320	The administrative assistant created a form for all new residents, including influenza vaccine, COVID v vaccine, RSV vaccine, Pneumonia vaccine, Tdap vaccine and the shingles vaccine. All new residents, upon admission will check either refuse or accept for all vaccines. The administrative assistant has added all historical vaccines into PCC on our current residents. The immunization checklist and TB1 and TB2 are on the audit sheet, that will be completed for every admission. The audit sheet for new admits will be used for six months, ending 9/30/26. This audit will be completed by the ED and administrative assistant. *Residents 1, 5, 8 and 11 were offered pneumonia vaccines on 3/12/26. Order requests have been faxed to the providers for those wanting the vaccine.* *All residents' records were audited for pneumonia vaccines on 3/5/26. For all applicable residents, the pneumonia vaccine was offered 3/12/26. Documentation of acceptance or refusal was documented. If the resident wanted the vaccine, the provider was faxed for an order. Once the vaccine is received, the DON will administer.*	3/22/26

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S 320	Continued From page 9	S 320		

pneumonia vaccine in their care records.

3. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed:
*They acknowledged there was no documentation for the pneumonia vaccinations or refusals in residents 1, 5, 8, and 11's medical records.
*They were aware that acceptance or refusal of the pneumonia vaccine was a state requirement for assisted living centers. The director of nursing (DON) was responsible for completing that assessment, but they did not have a current nurse or DON on staff. The as-needed nurse had not worked a shift since 12/19/25.

4. Review of the provider's undated Influenza/Pneumonia Vaccine policy revealed:
*"A resident's refusal of the vaccine shall be documented in the resident's medical record."

5. Review of the providers' undated Resident's Rights And Services Handbook revealed:
*"Pneumococcal vaccinations and annual influenza vaccinations are strongly encouraged for all residents."
*"The county health nurse, home health nurse, or facility nurse may offer the vaccine to residents wishing to participate. However, the vaccines may be waived for a resident because of religious beliefs, medical contraindication, or refusal by the resident."
*"Documentation of the vaccination or its waiver must be recorded in the "Staff Notes" section of the resident chart."

6. Review of the providers' Director of Nursing (DON) job description revealed:
*"The DON reports directly to the facility

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S 320	Continued From page 10 executive director on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations." *"Completes the required assessments in a timely manner, on each resident to determine level of care and care requirements." *"Ensures personal and medical data is entered into the electronic medical record of each resident in the facility."	S 320		
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary	S 331	The Administrative Assistant created a TB audit form for new staff and residents who admitted from November 2025 to present. Every new staff and resident, the ED or Administrative Assistant will audit and sign off on the sheet for the next six months, ending 7/31/26. The new DON started 2/23/26. *The TB form will be completed with the resident upon admission, by the ED. Residents 1, 5, 8 and 11 will receive their TB test on 3/16/26. All resident charts were audited for TB tests on 3/5/26. All applicable residents will receive their TB test on 3/16/26 and documented. The TB audit sheets are reviewed for residents upon admission.*	3/22/26

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S 331	Continued From page 11	S 331		

if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must 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 record review, interview, and policy review, the provider failed to ensure that a two-step tuberculin skin test was documented for four of eight sampled residents (1, 5, 8, and 11) within 21 days of their admission to the facility.

Findings include:

1. Review of resident 8's care record revealed:
*He was admitted to the facility on 1/15/26.
*There was no documentation of a completed two-step tuberculin skin test within the twelve months before his admission or within 21 days of his admission to the facility.

2. Review of residents 1, 5, and 11's care records revealed:
*Resident 1 was admitted on 12/8/23, resident 5 was admitted on 1/26/26, and resident 11 was admitted on 1/6/26 to the facility.
*None of the above residents had a documented tuberculosis screen in their care records.

3. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed:
*They acknowledged there was no

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THE VICTORIAN ASSISTED LIVING	1321 COLUMBUS ST. RAPID CITY, SD 57701

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documentation for the tuberculin 2-step skin testing in residents 1, 5, 8, and 11's medical records.
*They acknowledged that this could put other residents at risk of developing tuberculosis.
*The quality assurance and performance improvement (QAPI) team was doing a performance improvement project (PIP) on tuberculosis status screening and monitoring for staff and new residents.
*They acknowledged it was the director of nursing's (DONs) responsibility to assess and complete the 2-step tests and document them in the resident's medical record, but the facility did not have a current DON or a licensed nurse on staff.
*The as-needed registered nurse (RN) had not worked a shift since 12/19/25.

4. An immunization policy was requested on 2/4/26 at 2:00 p.m., and the provider did not provide a policy related to tuberculin screening and testing.

5. Review of the provider's undated Resident's Rights And Services Handbook revealed:
-"Each resident must have a two (2) step Mantoux test for TB within 30 days of moving into our facility. If the resident has a positive TB test in the past, they must have an evaluation performed by [a] physician."
-"A chest x-ray may be required by the physician to determine the presence or absence of TB. All positive test will be reported to the Department of Health by the Administrator or his/her designee."

6. Review of the providers' Director of Nursing (DON) job description revealed:
*"The DON reports directly to the facility executive director on all medically related matters

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which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations."
*"Completes the required assessments in a timely manner, on each resident to determine level of care and care requirements."
*"Ensures personal and medical data is entered into the electronic medical record of each resident in the facility."

S 337 44:70:04:11 Care Policies — S 337

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 interview, record review, policy review, and job description review, the provider failed to employ a licensed nurse since 12/19/25 to provide oversight and education for the unlicensed medication aides (UMAs) to ensure they performed duties safely and within their scope of practice according to state regulations and that individual care needs for residents were assessed and documented based on their unique medical conditions according to state regulations.

Findings include:

1. Interview on 2/3/26 at 3:00 p.m. with resident 2 revealed:
*The UMAs would "dial the dose" [insulin] for her, and she would administer the insulin injection herself.

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S 337	Continued From page 14 2. Interview on 2/3/26 at 4:10 p.m. with resident 6 revealed: *The UMAs would "dial the dose" [insulin] for her and administer the insulin injection to her. 3. Interview on 2/4/26 at 9:05 a.m. with administrative assistant B revealed: *She confirmed there were no UMAs at the facility that completed a required Diabetic Aide Course and were certified. *She was unaware that UMAs could not calibrate or administer insulin without the course training or without supervision of a licensed nurse employed by the facility. 4. Interview on 2/4/26 at 10: 30 a.m. with unlicensed medication aide (UMA) G revealed: *She stated that UMAs were allowed to "dial in" the dose on residents' insulin pens and inject insulin if the residents needed assistance. *She confirmed that she did not complete the diabetic training course and was not certified. *She stated that the facility currently did not have a nurse working at the facility. 5. Review of personnel records for UMA G, H, and I revealed: *UMA G completed five hours of the ten-hour Diabetes Aide Course through the South Dakota Board of Nursing website on 12/5/2024. She did not complete the test. *UMA's H & I did not start or complete a Diabetic Aide Course. 6. Observation on 2/4/26 at approximately 8:00 a.m. of resident 10 in the (Great Room) common area revealed: *Resident 10 had a witnessed fall when he stood up from his chair and fell to the floor onto his	S 337	The new DON started on 2/23/26. The DON is a proctor in South Dakota. As of 3/4/26 almost all of the med aides have completed the diabetic training course. Their certificates of completion have been placed in their employee files. All med aides will have the diabetic course completed by 4/1/26. The DON will cover the clinical check off list with all med aides. The check off from the DON for all med aides will be complete by 4/30/26. Staff have been educated to notify the DON of any falls and the DON will assess the patient. The new DON started 2/23/26. All falls will be audited by the ED and Administrative assistant until 7/31/26. The audit will include seeing that the DON was notified and an assessment completed. The Administrative assistant has created an audit form for assessments on new residents and assessments going forward. The ED and Administrative assistant will audit resident assessments until 7/31/26.	3/22/26

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S 337	Continued From page 15 side. *A number of unidentified staff and residents responded to resident 10's fall and asked him if he was injured. -Resident 10 denied any injuries or hitting his head with the fall. *UMA I questioned resident 10 about his fall and took his vital signs (clinical measurements that indicate a patient's body functions, such as pulse rate, temperature, respiration rate, and blood pressure). *It was observed that resident 10 was wearing one shoe at the time of his fall. *Resident 10 was assisted up from the floor by three staff members and back into his chair. 7. Observation on 2/4/26 at 8:30 a.m. at the nurse's station revealed: *There was a hot pink sign taped to the front of a cupboard behind the nurse's station that read: -"When to call and or text the nurse." -"Any Falls (call)." -"Call the nurse if any of the above occurs." 8. Review of resident 10's care record after his fall on 2/4/26 revealed: *There was no documentation that a licensed nurse was called and notified of his fall. *There was no nursing assessment of his fall on 2/4/26 documented in his care record. 9. Interview on 2/4/26 at 9:05 a.m. with administrative assistant B revealed: *She stated she did not know the fall policy, including whether a nurse should be called and if the residents needed to be assessed by a nurse after a fall. *She said that if a nurse was on duty and a resident fall occurred, the nurse would complete an assessment on the resident, but if the resident	S 337	*Med aides that are new hires will have 30 days from hire date to complete the diabetic training course and train with the DON. An audit sheet has been created with the med aides name and date this needs to be completed.* *The administrative assistant provided staff with education on fall protocol, notifying the DON, fall policy on 3/6/26.* *•The DON is on call 24/7, but if not available the staff would contact the manager on duty. The DON or on call would assess over the phone with staff, if serious 911 would be called to assess.* *The fall audit will also include if the fall policy was followed.*	

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reported no injury, then the unlicensed medication aides (UMAs) could assess them. If the resident had a serious injury or pain, the staff would call 911, send the resident to the emergency room, and notify the resident's representative.
*She acknowledged that the facility currently did not have a director of nursing (DON) or a licensed nurse employed.

10. Phone interview on 2/4/26 at 5:23 p.m. with licensed practical nurse (LPN)/director of clinical operations C revealed:
*She worked with the facility's management company that was located in Tennessee.
*She lived in Florida and was assisting the facility when able with nurse tasks that could be completed by telephone or remotely with the computer.
*She had worked like that since December 2025, when the DON resigned.
*She stated that the last time she was at the facility was over one year ago.
*She stated that since there was no nurse currently at the facility, administrative assistant B was completing the new admission paperwork, admission assessments, and service plans.
*She acknowledged that a nurse should complete the required resident assessments and service plans when needed.
*She stated that the UMAs should not be administering insulin or calibrating the insulin doses; that practice was not acceptable, and needed to have a nurse complete that or the resident, unless the UMA had taken the required diabetic training course and was certified.
*She said that there should be a nurse employed at the facility, and available on-call. The facility was in the process of hiring a new DON.
*She confirmed that a nurse was to be called or

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notified when a resident fell and that the resident was to be assessed by a nurse.
-She acknowledged that the as-needed nurse could be called, but she was unsure if that nurse still wanted to take those calls and come in for every resident fall to assess them.

11. Interview on 2/5/26 at 10:00 a.m. with UMA G revealed:
*She stated that the nurse needed to be called when a resident fell.
*She said that the nurse would only need to come into the facility to do an assessment on the resident if the fall caused a serious injury.
*If there was no serious injury, the UMA staff were to assess the resident and report the information to executive director A or administrative assistant B.

12. Review of the providers Unlicensed Medication Aide job description revealed:
*"Under the supervision of the nurse, the unlicensed medication Aide [UMA] administers medications as prescribed by the resident's physician, or other primary care providers, documents the administration, the effectiveness, and any noted adverse side effects of the medication in accordance with applicable state and federal regulations."
*"The UMA reports to the nujrse which is on duty or on call."
*"Observes, records, and reports to the nurse, symptoms and conditions of residents that could be related to medication interactions, adverse drug reactions or medication side effects."
*"Communicates with residents, staff and others in anaccurate and factual manner and seeks clarification from or refers questions to the nurse when indicated."

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S 337	Continued From page 18 13. Review of the Director of Nursing (DON) job description revealed: *"The DON reports directly to the facility executive director on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations." *"Completes the required assessments in a timely manner, on each resident to determine level of care and care requirements." *"Ensures personal and medical data is entered into the electronic medical record of each resident in the facility." *"The DON was responsible for destructions of all discontinued and expired non-controlled medications periodically." *"Supervisory: The DON supervises all nursing personnel to include other RNs, LPNs, Resident Care Assistants (RCA) and Certified Medication Assistants (CMA)." 14. Review of the provider's undated Injections policy revealed: *"Injectable medications will be administered by authorized licensed nurses or physicians, according to physician's orders and state regulatory requirements." *"Injections are administered only by the resident themselves or by a licensed medical professional. Licensed medical professional includes Doctors of Medicine (MD), Registered Designated staff persons (RN), and Licensed Practical/Vocational Nurses (LPN/LVN)." *"Licensed medical professionals administer only medications/insulin that they have drawn up, or have been predrawn by the pharmacy or the drug manufacturer." 15. Review of the provider's undated Falls policy revealed:	S 337		

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S 337	Continued From page 19 *"When a resident is determined to have a fall, they should be evaluated for injury and need for medical assistance. Basic first aid may be provided as allowed for by licensure/certification of available staff members. The resident should be evaluated for any noticeable red marks, bleeding, or injury of any kind. Medical provder will be notified of any noted injuries for appropriate intervention should occur." *"The Administrator instructs caregivers to provide appropriate care and frequent resident checks. Any change in status is reported to the Administrator." *"The service plan of the resident should be updated to reflect fall risk and any needed interventions to help minimize further fall risk."	S 337		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. 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 a 30-day evaluation of needs assessment was completed for two of three sampled residents (2 and 10). Findings include: 1. Review of resident 2's care record revealed: *She was admitted to the facility on 12/17/25. *Her evaluation of resident needs admission	S 352		

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S 352	Continued From page 20 assessment was completed on 12/17/25. *There was no documentation that her 30-day evaluation of needs assessment was completed. 2. Review of resident 10's care record revealed: *He was admitted to the facility on 2/25/25. *His evaluation of resident needs admission assessment was completed on 2/25/25. *There was no documentation that his 30-day evaluation of needs assessment was completed. 3. Interview on 2/4/26 at 4:56 p.m. with executive director A regarding the evaluation of resident needs assessment revealed: *She believed they were to be completed on admission, annually, and 30 days after admission to the facility. *The administrative assistant B had completed them since the director of nursing (DON) resigned in December 2025. *She stated that the DON was responsible for completing the 30-day evaluation of needs assessments, but they did not have a current DON or licensed nurse on staff. *The "as-needed" nurse did not work a shift since 12/19/25. *She acknowledged that there was no documentation for the 30-day evaluation of needs assessments in the medical records for residents 2 and 10. 4. Review of the providers' undated Ongoing Resident Appraisals policy revealed: *"Residents are assessed/evaluated on an ongoing basis." *"Resident will be formally assessed as required by state regulations." 5. Review of the providers' Director of Nursing (DON) job description revealed:	S 352	The new DON started on 2/23/26. She has received training on assessments by the corporate clinical director. Admission assessments, 30 day assessments and annual assessments will be audited by the ED and Administrative Assistant for six months, ending 7/31/26. *Resident 10's 30 day eval was completed on 9/6/25 by prior DON Resident 2's eval was completed on 2/10/26 by the Administrative Assistant.* *Recently admitted residents have been reviewed to ensure completion of the assessment.* *Assessments will be audited bi-weekly.* *Audits and assessments will be reviewed at QA for input and recommendations.*	3/22/26

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S 352	Continued From page 21 *"The DON reports directly to the facility executive director on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations." *"Completes the required assessments in a timely manner, on each resident to determine level of care and care requirements." *"Ensures personal and medical data is entered into the electronic medical record of each resident in the facility."	S 352		
S 485	44:70:06:11(1-3) ServSafe And Nutritional Needs The dietary manager, if employed, and at least one cook shall: (1) Successfully complete a ServSafe Food Protection Program and possess a current certificate; (2) Successfully complete the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association; or (3) Successfully complete equivalent training as determined by the department. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure at least one employee had taken the ServSafe course and possessed a current ServSafe certificate. Findings include: 1. Interview on 2.4.26 at 9:46 a.m. with dietary	S 485	The Dietary Director successfully completed the servsafe program on 2/28/26. The certificate is now displayed in the kitchen. A cook will also complete the servsafe program by 4/30/26. *The dietary director's certificate is displayed. It is the responsibility of the ED to ensure completion of servsafe. The expiration date is placed in the ED and dietary directors outlook calendar, 30 days prior to expiration.*	3/22/26

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director D revealed:
*He was in his role for 4 months and he had taken the ServSafe course but did not complete the test to become certified.
*He was not aware of any other cooks that were ServSafe certified by the provider.

2. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed:
*They did not have a staff member that was ServSafe certified.
*They stated that they were aware of regulations requiring the dietary director and at least one cook to have had a current ServSafe certification for food safety.

3. Review of the provider's food service cook job description revealed:
*The cook was responsible for "handling and preparing food in a sanitary manner."
*"Training for institutional food service and special meal preparation courses are a plus but not required."

4. Review of the provider's food service director job description revealed:
*The food service director "must be "Serve Safe [ServSafe]" certified or have equivalent training."

S 603 44:70:07:01(4) Policies And Procedures — S 603

Each facility shall establish and implement written policies and procedures for medication control that include:

(4) The proper disposition of medicines due to:
(a) Resident discharge;
(b) Resident death;

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(c) Outdated medication; or
(d) The prescription being discontinued by the physician, physician assistant, or nurse practitioner.

This Administrative Rule of South Dakota is not met as evidenced by:
Based on observation, interview, and policy review, the provider failed to ensure expired medications and medicated dressings were removed and discarded according to the provider's policy from one of one medication room.

Findings include:

1. Observation and interview on 2/4/26 at 10:30 a.m. with unlicensed medication aide (UMA) G revealed:
*Her medication cart appeared clean and organized, and did not have any expired medications.
*She stated it was everyone's responsibility to check for expired medications and supplies, and that there was no process in place.
*If she found an expired medication, she would place it in a labeled plastic bag, place that bag in the garbage bag used for the medication disposal bag, and lock it in the medication room.
*She stated that the pharmacist went through the medication carts monthly to check for expired medications, but did not check the medication room.
*The nurse would sometimes check the medication room for expired medications and supplies, but she said the facility had no director

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S 603	Continued From page 24 of nursing (DON) or registered nurse (RN) available at the facility. *She stated that medications require a nurse and the pharmacist to be destroyed, and were locked in a safe in the medication room. *She stated that it was a nurse's responsibility to destroy the medications. 2. Observation and interview on 2/5/26 at 10:00 a.m. with UMA G in the medication room revealed: *The door was locked. *The room was small, appeared cluttered, and felt warm. *There were expired medications that needed destroyed, stored in a large white garbage bag on the floor just inside the medication room door. *There was a small black safe on the floor inside the medication room that was locked. -UMA G stated that the safe contained the controlled medications that needed destroyed by the nurse and pharmacist. *The shelves in the medication store room contained the following expired medications and supplies: -Two 12 oz (ounce) bottles of Alumina, Magnesia, and Simethicone Oral Suspension that expired on 03/24. -One box (6 patches) of Lidocaine 4% pain relieving patches had expired on 6/5/24. 4. -One opened package of Xeroform (medicated) 2" x 2" occlusive gauze patch that expired on 1/31/25. -One opened package of Restore (medicated) silver dressing that expired on 09/2021. *She agreed that the medications had expired and should have been removed and disposed of appropriately. *She stated that the facility did not have a process for going through their medication room	S 603	The new DON started 2/23/26. The pharmacist consultant was contacted regarding checking for expired medications and supplies in the med room. The Pharmacist consultant will now check the med room during her monthly pharmacy review. Administrative Assistant created an audit form for education that includes OTC labels, expiration dates, expired meds, discontinued meds, resident discharge with or without meds, med destruction, six rights, dating medications, open dates , med fridge temps and med room temps. This will UMA education was completed on 3/5/26. Administrative Assistant created an audit for the medication carts and med room. This audit has dates on medications, labels on OTC's, any expired medications in carts and med room, correct labels with times. The DON will complete this audit weekly for one month and then once a month /for six months, ending 7/31/26.	3/22/26

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S 603	Continued From page 25 on a routine basis to check for expired medications and supplies, and was unsure when this was last completed. 3. Interview on 2/4/26 at 4:15 p.m. and again on 2/5/26 at 4:36 p.m. with executive director A revealed: *She expected staff to check for expired medications and to dispose of them properly. *She acknowledged it was the DON or a licensed nurse's responsibility to check for expired medications and supplies and dispose of them properly. *She was unsure if there was a process in place for this and stated that there was no DON or nurse available. -The as-needed nurse did not work a shift since 12/19/25. *She agreed that the medications and medicated dressings from the medication room were expired and should have been removed and disposed of appropriately. 4. Review of the providers' Director of Nursing (DON) job description revealed: *"Ensures destruction of all discontinued and expired non-controlled medications periodically." *"Safeguards all expired and discontinued narcotics/controlled medications until such time they are logged and destroyed." *Checks residents' rooms on a regular basis for medications that may have expired." 5. Review of the provider's undated Expired Medications policy revealed: *"Expired medication will not be given to any resident or responsible party, nor retained in the community [facility]." *"The Designated staff person inspect containers regularly for expiration dates."	S 603	The DON will go through resident rooms looking for expired self administer medications once month for six months, ending 7/31/26. Administrative Assistant created an audit sheet for this. *The pharmacist started doing monthly med room checks on 2/24/26. The pharmacist will report any findings to the DON for follow up.* *The DON completed medication education with the UMA's.* *Change the wording from "The DON will go through resident rooms" to The DON will review residents' bedside medications for expired medications.* *Expired medications will be reviewed at QA for input and recommendations.*	

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S 603	Continued From page 26 *"To properly dispose of expired medications the Designated staff person and another adult witness who is not a resident dispose of the medication per state regulations."	S 603		
S 630	44:70:07:04 Storage And Labeling Of Medications All medications must be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight degrees centigrade. 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 observed refrigerator was free from resident access to medications, and one of one observed medication storage room temperature was maintained at a consistent and acceptable temperature and documented. Findings include: 1. Observation on 2/3/26 at 9:40 a.m. revealed resident 11 was walking up the stairs from the dining room that led to a hallway upstairs. There was a door to a storage room in that hallway that was open.	S 630	The ED placed a thermometer in the med room. The med room temps are being audited by the ED and Administrative Assistant. The temp logs will be checked daily for a week and then once a week for six months, ending 7/31/26. *The med room is warm due to being under the stairs and not having ventilation. Maintenance is exploring the option of putting in a vent in the wall.* *Staff were educated about checking the med room temp on 2/5/26. Staff will be provided with education on why we are taking the temps, parameters of acceptable temps, and what to do if the temp exceeds the acceptable range on 3/13/26.* *Temp audits will be reviewed at QA for input and recommendations.*	3/22/26

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S 630	Continued From page 27 2. Observation on 2/3/26 at 11:04 a.m. of the second floor storage room revealed: *The door to the second floor storage room was open. *There was a refrigerator in the storage room that was unlocked. *That refrigerator had a small plastic compartment on the inside of the door with a clear plastic door. An unlabeled syringe was visible through that clear plastic door. The syringe had a cap on it and 10 ccs of clear liquid in it. There was an unopened alcohol pad sitting next to the syringe. 3. Interview on 2/3/26 at 5:28 p.m. with executive director A revealed: *She acknowledged that this storage room was left unlocked and that residents who were able to climb the stairs would have access to the room. *She acknowledged that the syringe likely contained a medication that belonged to a resident. She agreed that there was no way to know what medication was in the syringe or how long it was sitting in that refrigerator. *They did not have a current full-time nurse or director of nursing (DON) staffed at the facility. *The consulting pharmacist did not come to the facility to monitor expired or discontinued medications. 4. Observation and interview on 2/5/26 at 10:00 a.m. with UMA G of the medication room revealed: *The door was locked. The room contained residents' unused medications, resident supplies, and medications to be destroyed. *The room was small, appeared cluttered, felt warm, and there was no thermometer observed. *UMA G acknowledged that the medication room	S 630	The ED will provide education to all staff about medications only being stored in the medication fridge by the nurse station. Staff will sign off on this education by 3/30/26. The ED will audit the upstairs fridge once a week for a month and then once a month for six months, ending 7/31/26.	

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S 630	Continued From page 28	S 630		

did not have a thermometer and no temperatures were monitored or maintained for the medication room.
*The temperature was checked by this writer and read 81.7 degrees Fahrenheit (F) with the door open.
*UMA G stated that the room gets warm, and there was no ventilation for air to move around.

5. Interview on 2/5/26 at 10:30 a.m. with executive director A revealed:
*She had contacted maintenance to place a thermometer in the medication room immediately.
*She stated that she was unaware that the medication room needed to have temperatures monitored and maintained.
*She acknowledged that the room was warm and could potentially be a problem for medication storage.

6. Review of the provider's undated Medication Storage policy revealed:
*"Medications will be stored in a manner that ensures maintenance of both the integrity of the medication and the safety of all residents residing in the community [facility]."
*"All medications, including over-the-counter, are kept in locked storage at all times."
*"All medications must be stored in accordance with label instructions (refrigerate, room temperature, out of direct sunlight, etc.)."
*"Medication requiring refrigeration are stored in separate, locked refrigerator that is used solely for medication storage."

7. Review of the provider's DON job summary revealed:
*"The DON was responsible for destructions of all discontinued and expired non-controlled medications periodically."

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S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that a medication was labeled for one of four sampled residents (7) for one of one over-the-counter (OTC) medication container. Findings include: 1. Observation and interview on 2/5/26 at 8:00 a.m. with unlicensed medication aide (UMA) H during medication administration revealed: *The medication cart contained resident 7's medications. -An OTC medication container did not have a pharmacy label on it or any other identifying information for resident 7 on the container. -It contained the manufacturer's label of "Prilosec 40 mg [milligram]".	S 632	Administrative Assistant created an audit for the medication carts and med room. This audit has dates on medications, labels on OTC's, any expired medications in carts and med room, correct labels with times. The DON will complete this audit weekly for one month and then once a month for six months, ending 7/31/26. *Resident 7s OTC med was properly labeled on 3/10/26. The ED confirmed this on 3/10/26.* *All Resident's OTC meds were reviewed for proper labeling on 3/10/26. The ED confirmed this on 3/10/26.* *Staff education was provided on 3/10/26 in regards to looking at medication labels prior to administration. They were also educated on what should be on the medication label.* *The pharmacist will look for proper labeling during the monthly pharmacy review.* *Proper medication labeling will be reviewed at QA for input and recommendations.*	3/22/26

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*UMA H acknowledged that the OTC medication was prescribed for resident 7 by his physician according to his care record.
-There was no pharmacy label on the medication container that provided resident 7's information or instructions for administration related to the physician's order.

2. Interview on 2/5/26 at 4:36 p.m. with executive director A revealed:
*All medications should have a pharmacy label that includes the required identifying information and instructions for use.
*The medication label should match the physician's order for that medication.
*She expected the staff to check the label on medication containers, bottles, and cards to ensure safe medication administration.
*She stated that the pharmacist checked medications in the medication carts monthly, and that it was the pharmacist's and nurse's responsibility to complete that task.
*She acknowledged that no director of nursing (DON) or licensed nurse was employed at the facility since 12/19/25.

3. Review of the Director of Nursing (DON) job description revealed:
*"Supervisory: The DON supervises all nursing personnel to include other RNs, LPNs, Resident Care Assistants (RCA) and Certified Medication Assistants (CMA)."

4. Review of the provider's undated Medication Labels policy revealed:
*"Community [facility] staff does not alter prescription labels."
*"If a medication is changed or discontinued the current medication will be removed from the administration protocol and a complete new

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S 632	Continued From page 31 medication with correct label will be obtained."	S 632		
S 680	44:70:07:08 Medication Records And Administration A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the medication labels and the resident's electronic medication administration record (EMAR) matched during observed medication administration for one of four sampled residents (4). Findings include: 1. Observation and interview on 2/5/26 at 8:00 a.m. with unlicensed medication aide (UMA) H during medication administration revealed: *The medication cart contained resident 4's medications. *The resident's Senna-Docusate Sodium medication (a medication to treat constipation) pharmacy label on the medication bubble pack card read "Take 2 tablets - 8.6 mg (milligrams) /	S 680	All UMA's will review medication management by 3/30/26. The information contains making sure to verify the medication with the physician order and EMAR. It also includes proper labels for medications. All UMA's will sign off on this education. The new DON started 2/23/26 and is verifying physician orders. The Administrative Assistant has created an audit form for correct labels and times. The DON will complete the audit once a week for a month, then once a month for six months, ending 7/31/26. *If the med label does not match the MAR, it needs to be reported to the DON so that she can verify with the order for correct information.* *The DON will complete the physician order verification upon admissions, Dr. visits or new orders.* *The DON will audit UMA' s during med pass once a week for a month and then once a month for six months, ending 7/30/26.* *Med labels and med pass will be reviewed at QA for input and recommendations.*	3/22/26

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50 mg - by mouth at bedtime."
-The medication bubble pack card had a pharmacy sticker at the top that read "BEDTIME."
*Her February EMAR read "Senna-Docusate Sodium Oral Tablet 8.6-50 mg - Give 2 tablets by mouth one time a day in the morning for constipation. (Hold medication when resident has diarrhea)."
*The resident's Lipitor (atorvastatin calcium) medication (a medication to treat high cholesterol) pharmacy label on the medication bubble pack card read "Take 1 tablet - 40 mg - by mouth at bedtime."
-The medication bubble pack card had a pharmacy sticker at the top that read "BEDTIME."
*Her February EMAR read "Lipitor Oral Tablet 40 mg - Give 1 tablet by mouth one time a day in the morning related to Hyperlipidemia."
*UMA H agreed that resident 4's medication labels for those two medications did not match the physician orders on the EMAR.
*She was not sure why they did not match and stated that the medication cards came from the pharmacy with the labels.
*She stated that she did not know if a nurse checked the resident's medication cards for missing or incorrect labels.
*She acknowledged that there currently was no director of nursing (DON) staffed at the facility.

2. Interview on 2/5/26 at 4:36 p.m. with executive director A revealed:
*All medications should have a pharmacy label that includes the required resident identifying information and instructions for use.
*The medication label should match the physician's order for that medication.
*She expected the staff to check the label on medication containers, bottles, and cards to ensure safe medication administration.

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S 680	Continued From page 33 *She stated that the pharmacist checked medications in the medication carts monthly, and that it was the pharmacist's and nurse's responsibility to complete that task. *She acknowledged that no DON or licensed nurse was employed at the facility since 12/19/25. 3. Review of the Director of Nursing (DON) job description revealed: *"The DON reports directly to the facility executive director on all medically related matters which pertain to staff or to residents and on all documentation regarding that care in accordance with federal and state regulations." *"Completes the required assessments in a timely manner, on each resident to determine level of care and care requirements." *"Ensures personal and medical data is entered into the electronic medical record of each resident in the facility." *"Supervisory: The DON supervises all nursing personnel to include other RNs, LPNs, Resident Care Assistants (RCA) and Certified Medication Assistants (CMA)." 4. Review of the provider's undated Medication Labels policy revealed: *"Community [facility] staff does not alter prescription labels." *"If a medication is changed or discontinued the current medication will be removed from the administration protocol and a complete new medication with correct label will be obtained."	S 680		
S 775	44:70:09:02 Facility To Inform Resident Of Rights Prior to or at the time of admission, a facility shall inform the resident, both orally and in writing, of the resident's rights and of the rules governing	S 775		

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S 775	Continued From page 34 the resident's conduct and responsibilities while living in the facility. The resident shall acknowledge in writing that the resident received the information. During the resident's stay the facility shall notify the resident, both orally and in writing, of any changes to the original information. 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 that a written copy of the resident's rights was provided to one of three sampled residents (2) upon her admission to the facility. Findings include: 1. Review of resident 2's care record revealed: *She was admitted to the facility on 12/17/25. *Her care record did not contain documentation that a written copy of the resident's rights was provided on her admission to the facility. *She did not sign or receive a written copy of the resident's rights upon her admission to the facility until 1/16/26, which was not within the required timeframe. 2. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed: *Administrative assistant B stated she or the executive director completed the resident's rights on admission. *They expected the residents to be informed both orally and in writing of their resident's rights upon admission to the facility. *They acknowledged that resident 2's written resident's rights was not signed upon her admission. *They acknowledged that resident 2's written	S 775	The Administrative Assistant has created an admissions audit. All new admissions will be audited by the ED and Administrative assistant for six months, ending 7/31/26. Included on the audit form is having the lease completed, resident rights provided, Assessments date, TB1, TB2, Immunization check list and care plan. *Resident 2 received a copy of their rights on 12/30/25 by the Administrative Assistant.* *All resident files have been audited and have resident rights provided. This was audited by the Administrative Assistant.* *Resident rights will be reviewed at QA for input and recommendations.*	3/22/26

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S 775	Continued From page 35 resident's rights were signed 30 days after her admission on 1/16/26. 3. Review of the provider's undated Resident's Rights policy revealed: *"Resident Rights is provided to new admitting residents and/or residents responsible party."	S 775		
S 791	44:70:09:03 Facility To Provide Information A signed and dated admission agreement between the resident or the resident's legal representative and the facility must include information described in subdivisions (1) through (8), inclusive. The resident or resident's legal representative and the facility shall complete the admission agreement before or at the time of admission and before the resident has made a commitment for payment for proposed or actual care. The agreement must be printed in a manner to ensure ease of reading by the resident prior to signing. Any change in the admission agreement must be signed and dated by the resident or the resident's legal representative as an addendum to the original agreement. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure that the admission (lease) agreement was completed for one of three sampled residents (2) upon admission to the facility. Findings include: 1. Review of resident 2's care record revealed: *She was admitted to the facility on 12/17/25.	S 791		

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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 791	Continued From page 36 *Her care record did not contain documentation of her completed admission (lease) agreement when she was admitted to the facility. *She did not sign an admission (lease) agreement upon her admission to the facility until 1/16/26. 2. Interview on 2/5/26 at 4:36 p.m. with executive director A and administrative assistant B revealed: *Administrative assistant B stated that she or executive director A completed the admission (lease) agreements when a resident was admitted to the facility. *They expected that the admission (lease) agreements would be signed by the resident or the resident's representative upon admission. *They acknowledged that resident 2's admission (lease) agreement was not signed upon her admission. *They acknowledged that resident 2's admission (lease) agreement was signed 30 days after her admission on 1/16/26. 3. Review of the provider's 60 Day Term Resident Agreement revealed: *"Entirety of Lease Agreement." *"Resident/responsible party has received a copy of resident handbook, Tenant/landlord rules and reviewed entire lease, either on their own or with a facility representative. The resident/responsible party has been given an opportunity to ask any questions related to policies and procedures, regulations, and service pricing."	S 791	The Administrative Assistant has created an admissions audit. All new admissions will be audited by the ED and Administrative assistant for six months, ending 7/31/26. Included on the audit form is having the lease completed, resident rights provided, Assessments date, TB1, TB2, Immunization check list and care plan. *Resident 2's was signed 1/16/26 by the Administrative Assistant. All resident files have been audited by the administrative assistant and have completed information. Lease agreements will be discussed at QA for input and recommendations.*	3/22/26