STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10767	A. BUILDING: _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK AT ALL SAINTS	111 WEST 17TH STREET SIOUX FALLS, SD 57104

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S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/22/24 through 10/24/24. Touchmark At All Saints was found not in compliance with the following requirements: S105, S169, S201, S443, S650, S680, and S800. 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 10/22/24 through 10/24/24. Areas surveyed included a resident's toileting needs and incontinence care, a residents injuries, removal of a resident's video monitoring by family, a resident receiving professional nurse care in a timely manner, provision of meals to a resident, and sufficient care staff. Touchmark At All Saints was found not in compliance with the following requirement: S800.	S 000		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy	S 105		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive Director (X6) DATE 11.15.2024

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S 105	Continued From page 1 review, the provider failed to ensure one of one sampled kitchen was maintained in a clean and sanitary manner. Findings include: 1. Observation on 10/23/24 at 4:07 p.m. of the main kitchen revealed: *The ice cream freezer contained two containers of ice cream that did not have lids covering them. -The ice cream appeared to have had a frost build-up on it. *In the preparation area the dry storage wire rack had: -A brown dried residue on the front of one shelf and powdered chocolate pudding was stored that shelf. -A thick layer of dust covered the wires on the shelf shelf cake mix was stored on. *The flour bin plastic cover had an area of missing plastic on the front that measured approximately one and one-half inch by one inch. *The commercial mixer had numerous areas with a thick dried substance on it. *The walk-in-refrigerator had: -Raw chicken breasts, that were not covered, stored on a rack in the middle of the refrigerator. -A cake covered with plastic wrap was stored next to the raw chicken breasts. -There were four black to-go food containers. --One included a handwritten label of "Germ choc" and was not dated. --The remaining three containers did not have a label or date. -Numerous crumbs from various food items, a torn piece of plastic wrap measuring 5 inches by 2 inches, and peanuts were on the floor. *The walk-in freezer had: -On the floor, an oblong piece of ice that measured approximately 2 inches by 3 inches. -Eight breakfast pizzas stored on a rack that was not covered or dated.	S 105	S105 All Dining Service Team Members will complete training on properly covering Ice Cream Containers by December 6th, 2024 Monitoring: An audit of properly covering ice cream containers will be completed daily for 30 days by the dining services manager on duty. The results of the daily audits will be utilized to confirm system processes are achieved and desired outcomes met or if adjustments/additional training is necessary. The audits will continue weekly for three months. The QA committee will review the results of the audits weekly for 4 weeks then monthly for 3 months and recommend further action as necessary. The Dining Services Director will review audits after they have been completed. Dining Services Director is responsible. S105 All Dining Services Team Members will be shown how to properly clean and maintain all metal storage racks before December 6th, 2024 Monitoring: Audit will be completed to verify the proper cleaning of the metal storage racks. Dining services manager on duty will conduct daily audits for 30 days. The results of the daily audits will be utilized to confirm system processes are achieved and desired outcomes met or if adjustments/additional training is necessary. The audits will continue weekly for three months. The QA committee will review the results of the audits weekly for 4 weeks then monthly for 3 months and recommend further action as necessary. The Dining Services Director is responsible to review audits after they are completed. Dining Services Director is responsible. The dry storage racks were cleaned on 10-23-24 to remove build up and dust.	12/6/24

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S 105	Continued From page 2 *The storeroom located in the dishwashing area had an opened large bag of rice that was not sealed or dated. *The dishwasher area wall had a black residue that appeared to be mold extending from the stainless-steel backsplash of the dishwasher up to the hood vent. *The preparation area freezer had: -An interior exhaust fan that had ice build-up on it measuring approximately 4 inches by 6 inches in an irregular shape on the wire grates. -Numerous areas of ice build-up on the floor underneath of the exhaust fan and on the shelves. -The door of that freezer did not close tightly and had ice build-up around the interior edge of the door. Interview on 10/24/24 at 4:50 p.m. with manager dining services F revealed: *He confirmed: -All food should have been covered or in a closed container. -All food should have been labeled and included a date that the food was made. -The flour bin cover, which was damaged, should have been replaced. *The dry food storage wire racks were taken outside and sprayed down every three months. -He was not aware of the dried substance and dust on the shelves. *He was not aware of the food dried on the commercial mixer; he thought it was chipped paint. *The freezer in the preparation area with the ice build-up was new "about four months ago" and should not have had ice buildup in it. *The black residue, which appeared to be mold, on the wall behind the dishwasher was not mold and was not cleanable.	S 105	S105 The Director of Dining Services will conduct an in person training on how to properly take apart and clean the commercial mixer before December 6th, 2024. A laminated poster will be created showing the proper steps to take apart the mixer and posted by December 6th, 2024. Monitoring: An audit verifying the proper cleaning of the mixer will be completed daily for 30 days then weekly for 3 months by the dining services manager on duty. The results of the daily audits will be utilized to confirm system processes are achieved and desired outcomes met or if adjustments/additional training is necessary. The audits will continue weekly for three months. The QA committee will review the results of the audits weekly for 4 weeks then monthly for 3 months and recommend further action as necessary. The Dining Services Director is responsible to review completed audits. Dining Services Director is responsible. S105 Flour Bin Replacement. New Flour and Sugar Bins have been ordered to replace the cracked ones. The new bins were delivered on November 7th, 2024. Monitoring: Dining services manager on duty will do daily audits for 30 days and then weekly audits for 3 months to make sure bins are in great working order. Dining Services Director is responsible to review completed audits. Dining Services Director is responsible. Chicken breasts were covered and cooked on 10-23-24. Cake was covered and moved to another shelf. "Germ Choc" was thrown in the garbage along with the 3 unmarked containers and breakfast pizza. Rice was placed in a food safe bin on 10-23-24. The mixer was taken apart and properly cleaned on 10-23.24.	

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S 105	Continued From page 3 Review of the provider's undated Food Storage and Labeling policy revealed: *"All foods must be stored in a manner that retains food quality and prevents foodborn [food-borne] illnesses." *"Cover tightly and seal all food items with plastic wrap or a lid", *"Label and date food with the product name, the date it was opened or prepared, the name of the person who opened/prepped it, the use-by date or shelf life, and the Manager's signature". *"To avoid waste, make sure products are appropriately labeled and used before they expire". Review of the provider's undated Cleaning Instructions: Freezers revealed: *"Freezers will be defrosted as needed (when frost is greater than ¼ inch thick, the freezer should be defrosted), or per the manufacturer's instructions." Review of the provider's undated Cook Detail Cleaning Sheet revealed: *"Friday: -Defrost freezers on line and restock" -"Detail storage racks (making sure each shelf is cleaned". Review of the provider's undated Dishwasher Detail Cleaning Sheet revealed: *"Scrub wall under sink and behind faucet."	S 105	S105 The Director of Dining Services and Sous Chef will conduct an in person training on proper storage of food items, Labeling food items and Cleaning floors in the Walk in Cooler and Freezers by December 6th, 2024 Monitoring: Cleaning checklists will be completed after each shift and signed off by the dining manager on duty. At the end of each shift, the lead server and cook will verify all tasks were completed and sign off. Dining services manager on duty will conduct daily audits for 30 days ensuring compliance of daily cleaning checklist and follow up. The results of the daily audits will be utilized to confirm system processes are achieved and desired outcomes met or if adjustments/additional training is necessary. The audits will continue weekly for three months. The QA committee will review the results of the audits weekly for 4 weeks then monthly for 3 months and recommend further action as necessary. The Dining Services Director is responsible to review completed audits. Dining Services Director is responsible. S105 Walk in Freezer Ice buildup. IS Restaurant and Design has been called to come look at and adjust the doors on the freezers where air is getting in and causing the ice buildup. They are scheduled to come before December 2nd, 2024. Monitoring: Dining Services Leader on duty once completed will do a daily check to make sure freezer doors are closing correctly and that no ice is forming. Dining Services Director is responsible. Dining Services Director conducted a visual audit of the kitchen to identify any other areas that potentially were out of compliance and did not find further issues not previously identified.	
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm,	S 169		

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S 169	Continued From page 4 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 observation, testing, and interview, the provider failed to install door alarms that do not automatically silence for one randomly observed stair tower (center stair tower). Findings include: 1. Observation and testing on 10/23/24 at 11:50 a.m. revealed the door to the central stair tower was provided with a delayed egress electric door lock. Testing of that delayed egress lock revealed it would alarm when activated. Further testing of that electric lock revealed it would stop alarming sometime after the door had closed. The exterior door from the lounge in the assisted living was equipped with a door alarm. Interview with the building services manager G at that same time confirmed those findings. He also revealed the assisted living had residents in that unit with some cognitive impairments. Further interview with the building services manager revealed the alarm of that electric door lock was what they used to know if that door had been opened by someone without an electronic door key.	S 169	S169 The Building Services Director is actively coordinating with low voltage electrical contractors to adjust the door alarm settings for the door identified in the survey so that alarms will sound continuously until reset with a code or badge swipe. The Building Services Director reviewed all unattended exit doors & discovered one other in this neighborhood which will be addressed and adjusted to meet the requirement. A Building Services Technician will perform monthly checks on these alarmed doors as part of the preventative maintenance program going forward, with each check recorded in the TELS program to confirm alarm functionality. For the next six months, the Building Services Director will review the logs monthly and follow up on any issues to ensure compliance. The Building Services Director is responsible for ensuring compliance.	12/8/24
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged,	S 201		

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S 201	Continued From page 5 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: A. Based on observation testing and interview, the provider failed to maintain the required fire resistive design for three randomly observed fire walls (outside room 305, outside room 342, and outside room 304) as required. Findings include: 1. Observation and testing on 10/23/24 at 2:48 p.m. revealed the leaves of the 90-minute fire-rated cross-corridor in the fire wall adjacent to room #305 were not closing and latching into the door frame when released from the fire alarm controlled magnetic hold-open devices. Those doors must close and latch to maintain the required fire resistive design of that wall assembly. Interview with building services manager G at the time of the observation confirmed that finding. 2. Observation and testing on 10/23/24 at 2:56 p.m. revealed the north of the 90-minute fire-rated cross-corridor in the fire wall adjacent to room #342 was not closing and latching into the door frame when released from the fire alarm controlled magnetic hold-open device. That door leaf must close and latch to maintain the required fire resistive design of that wall assembly.	S 201	S201 The leaves of the fire-rated cross-corridor fire walls outside room 305, outside room 342 & outside room 304 will be adjusted to properly close & latch into the door frame when released from the fire alarm controlled magnetic hold-open devices. Elevator lobby fire doors at 2nd & 3rd Floors North Elevator & 3rd Floor Main Elevator will be adjusted to property close & latch into the door frame when released from the fire alarm controlled magnetic hold-open devices. The 1st Floor fire doors next to the bank as well as the 2nd Floor fire doors next to room 223 will have the latches repaired to ensure the doors will open when the push bar is pressed. The 1st Floor door to the Center South Stair Tower will be adjusted to ensure the door will close & latch into its door frame when operated. On 10/31/24, the Building Services Manager conducted a facility-wide review of all fire doors in partnership with Steve Dremph Construction. A quote is currently being obtained for necessary repairs to any doors found to be malfunctioning, and these repairs will be completed by Steve Dremph Construction by 11/24/24.	12/8/24

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S 201	Continued From page 6 Interview with building services manager G at the time of the observation confirmed that finding. 3. Observation and testing on 10/23/24 at 3:14 p.m. revealed the south leaf of the 90-minute fire-rated cross-corridor in the fire wall adjacent to room #304 was not closing and latching into the door frame when released from the fire alarm controlled magnetic hold-open device. That door leaf must close and latch to maintain the required fire resistive design of that wall assembly. Interview with building services manager G at the time of the observation confirmed that finding. B. Based on observation testing and interview, the provider failed to maintain the required fire resistive design of elevator shafts at three randomly observed locations (second floor north elevator, third floor north elevator, and third floor main elevator) as required. Findings include: 1. Observation and testing on 10/23/24 at 12:23 p.m. revealed the elevator lobby door to the north elevator shaft on the second floor was not closing and latching into the door frame when released from the fire alarm controlled magnetic hold-open device. That door leaf must close and latch to maintain the required fire resistive design of that elevator shaft. Interview with building services manager G at the time of the observation confirmed that finding. 2. Observation and testing on 10/23/24 at 2:07 p.m. revealed the elevator lobby door to the north elevator shaft on the third floor was not closing and latching into the door frame when released from the fire alarm controlled magnetic hold-open	S 201	S 201 Continued from page 6 Additionally, the Building Services Director has coordinated with Dekomo to initiate bi-annual adjustments for fire doors to maintain compliance moving forward. Monthly fire door checks are a part of the preventative maintenance plans & will continue to be performed by a Building Services Technician, with each check recorded in the TELS program. To ensure the quality of these checks, The Building Services Director and Building Services Manager will do a training for all Building Services Technicians to go over the required functionality of fire doors. This training will cover what doors qualify as fire doors & need to be checked, how these doors need to close, latch, and open properly as a fire door. This training will be completed prior to 11/24/24. For the next six months, the Building Services Director will review the logbook monthly to ensure completeness and follow up on any issues identified, ensuring all doors are checked and promptly addressed if found to be non-compliant. The Building Services Director is responsible for ensuring compliance.	

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S 201	Continued From page 7	S 201		

device. That door leaf must close and latch to maintain the required fire resistive design of that elevator shaft.

Interview with building services manager G at the time of the observation confirmed that finding.

3. Observation and testing on 10/23/24 at 2:40 p.m. revealed the elevator lobby door to the main elevator shaft on the third floor was not closing and latching into the door frame when released from the fire alarm controlled magnetic hold-open device. That door leaf must close and latch to maintain the required fire resistive design of that elevator shaft.

Interview with building services manager G at the time of the observation confirmed that finding.

C. Based on observation testing and interview, the provider failed to maintain egress doors free of all obstructions to allow full use in case of emergency for two randomly observed locations (first floor fire doors next to the bank and second floor fire doors next to room 223) as required. Findings include:

1. Observation and testing on 10/23/24 at 10:18 a.m. revealed the south leaf of the 90-minute fire-rated cross-corridor doors outside of the bank on the first floor would not open when the push bar was pressed. That door's latch was found to be operating incorrectly and would essentially lock when it latched. The latch mechanism at the top of the door had to be manually manipulated to allow the door to release from its latched position. Leaves of doors in the path of egress must set into motion with a force no greater than 50 pounds of force applied at the latch stile.

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S 201	Continued From page 8 Interview with building services manager G at the time of the observation confirmed that finding. 2. Observation and testing on 10/23/24 at 10:18 a.m. revealed the west leaf of the 90-minute fire-rated cross-corridor doors outside of room 223 would not open when the push bar was pressed. That door's latch was found to be operating incorrectly and would essentially lock when it latched. The latch mechanism at the top of the door had to be manually manipulated to allow the door to release from its latched position. Leaves of doors in the path of egress must set into motion with a force no greater than 50 pounds of force applied at the latch stile. Interview with building services manager G at the time of the observation confirmed that finding. D. Based on observation testing and interview, the provider failed to maintain the required fire resistive design of stair towers at one randomly observed location (Center South Stair Tower) as required. Findings include: 1. Observation and testing on 10/23/24 at 11:50 a.m. revealed the first-floor door to the Center South Stair Tower did not close and latch into its door frame when operated. That door leaf must close and latch to maintain the required fire resistive design of that stair tower. Interview with building services manager G at the time of the observation confirmed that finding.	S 201		
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool	S 443		

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S 443	Continued From page 9 for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to evaluate and document a yearly cognitive status for three of seven sampled residents (1, 2, and 3). Findings include: 1. Review of the care record for resident 1 revealed: *His admission date was 4/27/23. *A Saint Louis University Mental Status (SLUMS) exam (an assessment tool to determine the level of cognition impairment or ability of a person) was completed on 11/2/22. *There was no yearly cognitive evaluation completed. Interview on 10/24/24 at 4:23 p.m. with clinical care manager (CCM) B regarding resident 1's SLUMS revealed: *The last SLUMS that was completed sometime in April 2023. -There should have been a SLUMS completed sometime in April 2024. -The registered nurse responsible to complete resident 1's SLUMS had not done so. 2. Review of the care record for resident 2 revealed: *Her admission date was 7/2/22. *She had resided in a memory care unit. *She was discharged on 6/26/24. *There was no yearly cognitive evaluation completed.	S 443	S443 Policy was updated to include memory care resident to have cognition screenings in accordance with state regulations. Licensed nurses will complete an audit on all resident charts and document in QUICKMAR when last cognition screening was completed. If over a year nurse will complete one within one week's time. CCM will then audit all charting in QUICKMAR regarding cognition screenings to ensure all have been completed by November 30th 2024. Audit will document all screenings that are overdue and when they were completed to be in compliance with annual assessments. This will be for all residents in licensed care. QUICKMAR alerts have been inputted for reminder tasks that have to be signed off by the nurse to have the cognition screenings done upon move in, 30 days after move in and annually thereafter. CCM will audit charts of all new move ins within 35 days to ensure they have been completed and audit monthly for all other residents to ensure annual cognition screenings are being completed and charted. This audit will be completed over a 6 month period. This audit will include the resident, the type of screening completed and the date it was completed. Digital copies will be uploaded to the HSD and CCM after completed by the nurse. QA committee to review audits weekly for 1 month then monthly for 3 months. Resident 1 and 3 will have their cognition assessments completed by 11/15/2024. Resident 2 is not an active resident. Clinical Care Manager is responsible.	12/8/24

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S 443	Continued From page 10 Interview on 10/24/24 at 3:53 p.m. with registered nurse D regarding resident 2's SLUMS exam revealed: *She was responsible for the completion resident 2's SLUMS. -She confirmed she was unable to find a SLUMS exam for resident 2. 3. Review of the care record for resident 3 revealed: *His admission date was 11/2/21. *A SLUMS exam was completed on 3/27/22. *There was no yearly cognitive evaluation completed. 4. Interview on 10/24/24 at 5:11 p.m. with CCM B regarding resident's SLUMS revealed: *Nurses were responsible to complete and document resident SLUMS on admission and yearly thereafter. *Her expectation was for the nurse to evaluate and document the SLUMS for each resident timely. 5. Review of the provider's Ancillary Nursing Assessment/Evaluation Guideline revealed a "SLUMS or Mini Cog" was to be completed upon move-in and annually or with a CIC (Change in Condition) for all residents except "MC1" (a level of care designated for a resident). 6. Review of the provider's undated Registered Nurse (RN) job description revealed: *"The Registered Nurse is part of a multi-functional team providing excellent care to meet the physical, cognitive, social, and spiritual needs of the residents." *"Must have a comprehensive understanding of state residential care licensure and regulations." *"Assess the health status of residents as	S 443		

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	10767	A. BUILDING: _____ B. WING _____	C 10/24/2024

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S 443	Continued From page 11 outlined in the state nursing standards and Boarding Home Regulations, and in collaboration with the Clinical Care Manager and Health Services team, develop and review the individual service plans as required by state regulations." *"Communicate assessment data in an orderly fashion by recording, updating and communicating among the Health Services team daily and revising as appropriate." *"Organize assessment data so that it is accurate, complete, and accessible, and so that it remains confidential."	S 443		
S 650	44:70:07:06 Drug Disposal Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy. This Administrative Rule of South Dakota is not met as evidenced by: Based on closed care record review, interview, and policy review, the provider failed to ensure one of three sampled resident's (5) medication destruction had been disposed of by two authorized personnel. Findings include: 1. Review of resident 5's closed care record revealed: *Her admission date was 11/9/22. *The provider utilized a paper "Medication Disposal Sheet" that included: -"Instructions: Use this form to record the	S 650	S650 Training was held for all medication aides and nurses on the proper procedures of filling out a medication disposition sheet for 3 of the pharmacies that are used on October 30th 2024. A policy and procedure was developed on November 7th, 2024 for completing a medication disposition form. Employees that were unable to attend the in person training will be assigned to review and understand of the policy and procedure of completing a medication disposition sheet on the Relias training platform and will be due by December 8th, 2024. This will also be assigned to all new team members that are administering medications via the Relias training platform. Nurses will do monthly audits for 6 months to ensure these are filled out completely and accurately. CCM will review the audits after nurses have them completed. Audits will include documentation of any discrepancies and follow up that was completed with that staff member. These audits with be reviewed by the QA committee once weekly for 1 month then monthly for 3 months. Clinical Care Manager is responsible.	12/8/24

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S 650	Continued From page 12 disposition, destruction and/or return of medications to pharmacy. An entry is required for each mediation along with reason for disposition and signature of person completing form and witness (if needed). Keep the completed and signed form with the medications for return to the pharmacy. Retain the carbon copy for facility records add store per facility policy." -There was a column with "Reason (Use Key Below)". -"Disposition Reason Key:" included: deceased, medication discontinued, discharged, destroyed, released to "customer/Resident", in hospital, and other. --Other included a line for writing what "Other" may have been. *Medication Disposal Sheets for resident 5 included: -Systane Gel Drops and Loperamide 2 mg capsules on 4/7/24 were signed by a certified medication aide (CMA). -Calcium Tab 600 mg on 4/21/24 was signed by a CMA. -Systane Gel on 4/30/24 was signed by a CMA. *There was no indication of the disposition reason for any of the above medications. Interview on 10/24/24 at 5:11 p.m. with clinical care manager B regarding medication destruction revealed: *She confirmed the Medication Disposition Sheets had not been completed accurately. -She stated the forms should have indicated what was done with the medications. *The process was for medications to be returned to the pharmacy to have one staff person sign the Medication Disposition Form. -That person was usually a CMA. -The reason for disposition should have been indicated on the form.	S 650		

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S 650	Continued From page 13 Review of the provider's 10/18/24 Discarding Medications policy included: *"Discarding of medications is necessary when the following occurs: -1. Medications expires/outdated -2. Medication is discontinued -3. Medication left behind when resident moves -4. Medication contaminated". *"In (electronic medical record): -When to use Med [Medication] Disposal - -The Med Disposal, or Med Destruction or Med Checkout feature is used whenever you want to make a record that you are getting rid of medications or need to decrease the current inventory of a counted drug. Examples included: --A caregiver dropped a pill --A med was DCd [discontinued] with pills left over --A resident is discharged and the meds are sent with him --Meds are returned to the pharmacy for a refund". -"A report shows you exactly what has been checked out, along with all the pertinent information." *"Recording the Disposition of Meds". '"To dispose of meds: -1. From the Home Page, click the Dispose of Meds button -2. A second person must stay and witness the whole process of destroying medications." -"Team members should never share passwords with each other when destroying medications." --"A licensed nurse and witness must destroy medications unless state regulations require two nurses to destroy." *The policy did not include the use of paper forms for medication disposal.	S 650		

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S 680	Continued From page 14	S 680		
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 record review, interview, and policy review, the provider failed to ensure physician's orders for resident weighing were accurately transcribed for one of two sampled residents (4) in her electronic care record (ECR). Findings included: 1. Review of resident 4's care record revealed: *Her ECR included a 9/6/24 physician order that indicated: -"Check weekly weight per doctor's orders - WEIGHT TWICE A WEEK FOR CHF, if wt. increases 2-3 lbs in one day or 5lbs in 1 week contact PCP [primary care provider]". -"Check weekly weight per doctor's orders - WEIGHT ONCE A WEEK FOR CHF, if wt. increases 2-3 lbs in one day or 5lbs in 1 week contact PCP". -Her ECR weight documentation was scheduled to be done "QTY [quantity] 1 EVERY TUE [Tuesday] 7 AM to 10 AM".	S 680		

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S 680	Continued From page 15 *The documented weights were recorded on the following dates: 10/1/24, 10/4/24, 10/15/24, and 10/22/24. Interview on 10/23/24 at 5:07 p.m. with CCM B regarding resident 4's physician order for obtaining her weights revealed: *There was a transcription error in the ECR and resident 4 should have been weighed twice weekly. *Nurses entered physician orders into the ECR. *She was unable to locate a paper copy of the physician order for resident 4's weighing. Interview on 10/24/24 at 5:11 p.m. with clinical care manager (CCM) B regarding resident 4's weighing revealed: *She had reviewed the order and documentation related to the 9/26/24 physician order for weighing. -She confirmed the order was confusing. -On 5/23/24 resident 4's physician order was to have her weights obtained twice per week. -On 6/5/24 that order had changed to have her weights obtained once per week. --She thought that order was changed to indicate the weights were to be done two times per week. -She was unable to locate the original physician order that indicated the weights should be changed to twice per week following the previous order for weekly weights. --The ECR area for documentation of her weights included that indicated that was to be completed only one time each week. -She agreed a staff member who documented weights should have identified this discrepancy. Review of the provider's 10/18/24 Physician Orders Policy revealed: *"All physician orders will be reviewed and	S 680	S680 Licensed nurses will attach a checklist of the order completion process to each order they receive and CCM will audit weekly all new orders to verify each step has been taken in the receiving and completing provider orders in accordance with facility policy and procedure and state regulation. The nurses will be required to sign the order checklist when they are completed. This will be completed for 3 months then discontinued if all order processes have been correctly followed. If any discrepancies found audits will continue until 30 days of audits have no errors. The audits will include documentation that ensures all steps were followed. These audits will be reviewed by QA committee once weekly for 1 month then monthly for 3 months. Clinical Care Manager is responsible. Resident 4's directions on the order was changed to the correct instructions to reflect physician's orders on 9-6-24	12/8/24

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S 680	Continued From page 16 renewed annually, or per state regulation. It may also require review and/or revision upon the return of a resident from the hospital, a skilled care facility, or with a change of condition." *"A nurse will note all order changes with date and their signature and nurse title." *"Nurse or designee will chart all medication changes and notifications required in resident's electronic medical record." *"All order changes will either be added by [pharmacy] (medication only) or [provider] Nurse or designee (treatments) into [ECR].	S 680		
S 800	44:70:09:04 Notification When Resident's Condition Change A facility shall immediately inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and, if known, notify the resident's legal representative or interested family member when any of the following occurs: (1) An accident involving the resident that results in injury or has the potential for requiring intervention by a physician, physician assistant, or nurse practitioner; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review the provider failed to ensure physician notification of one of seven sampled	S 800		

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S 800	Continued From page 17 resident's (6) change in condition. Findings include: 1. Review of resident 6's care record revealed: *His admission date was 7/15/22. *His diagnoses included: cognitive impairment, emphysema, and urinary retention. *His charting notes included that on 8/31/24 at 7:05 p.m. "[Staff member] called this writer to report that resident had an O2 [oxygen] under 81 earlier today. She gave him a neb [nebulizer treatment] and O2 improved. Later on, his O2 was 87 and she gave him another neb and O2 improved. She reports his bottom lip is slightly blue and fingers are cold but not blue and this is not unusual. She states his legs are very swollen, Nurse advised to notify family for resident to be evaluated at the hospital for possible CHF exacerbation to which she declined and states she will be coming to see him. [Staff member] is going to weigh resident to see if he has gained 5lbs [pounds] in a week's time and will administer lasix [medication for fluid retention]. Discussed this is not preferable due to timing but she foresees family would prefer that avenue before a hospital visit." Interview on 10/24/24 at 3:25 p.m. with licensed practical nurse E regarding resident 6's change of condition on 8/31/24 revealed: *She was on call at the time of the incident, and was notified while she was at home. -She confirmed she had documented in resident 6's care record on 8/31/24 at 7:05 p.m. his change in condition. *She had not notified resident 6's primary care provider (PCP). -The nurse scheduled the morning of 9/1/24 should have followed up on resident 6's condition and notified his PCP.	S 800	S800 An on call document for everyday was created for the licensed nurses to document any calls received from care team regarding resident care and the steps and/or directions given to care team to follow and/or action taken by the nurse. Nurses, CCM, and HSD to review this report every morning following the on call evening shift to ensure that anything that would need follow up that it is completed that day. CCM to audit licensed nurses that the follow up plan was executed correctly in accordance with state regulations and facility policy and procedure. This audit will be done daily and continue for 3 months then discontinued if all processes have been correctly followed. If any discrepancies found audits will continue until 30 days of audits have no errors. These audits will be reviewed by QA committee once weekly for 1 month then monthly for 3 months.Clinical Care Manager is responsible. Resident 6's condition was resolved on 9-1-2024.	12/8/24

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S 800	Continued From page 18 Interview on 10/24/24 at 5:04 p.m. with clinical care manager (CCM) B regarding physician notification of resident 6's change in condition revealed: *His PCP should have been notified of his change in condition. *She confirmed: -There was no documentation to support that his PCP had been notified of his change of condition. -There was no follow-up documentation. Review of the provider's 10/18/24 Physician Orders Policy revealed there was no indication of notification of a resident's change of condition.	S 800		