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
	67578	A. BUILDING: Edgewood Prairie Crossings Sioux Falls B. WING	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PRAIRIE CROSSINGS SIOUX FALLS, LL	1810 S DOROTHY AVE SIOUX FALLS, SD 57106

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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 on 8/26/25 through 8/27/25. Edgewood Prairie Crossings Sioux Falls, LLC was found not in compliance with the following requirements: S106, S165, S331, S352, and S685. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 8/26/25 through 8/27/25. Areas surveyed included resident quality of care and nursing services. Edgewood Prairie Crossings Sioux Falls, LLC was found in compliance.	S 000		
S 106	44:70:02:06 Food Service A facility of seventeen beds or more shall have a mechanical dishwasher. The facility shall have the space, equipment, supplies and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's recommendation review, the provider failed to ensure the water temperature required to sanitize the dishes used for preparing and serving residents' food was monitored and documented for one of one high-temperature dishwasher. Failure to ensure that increased the potential risk of foodborne illnesses for the entire resident	S 106	S 106: Dining Services Director will educate all dining staff on dish machine temping protocol to ensure it is reaching 180 degrees. Dishwashing policy reviewed, no changes made. Dish temps will be documented by dining staff 3 times a day (at breakfast, lunch and dinner) on a daily audit. ED or designee will conduct weekly audit weekly for 6 months. Dining Services Director or ED will present audit findings at monthly QAPI meetings.	10/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen J Dougherty | TITLE: Executive Director | (X6) DATE: 9/25/2025

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S 106	Continued From page 1 population who received meals served from that kitchenette. Findings include: 1. Interview on 8/26/25 at 11:20 a.m. in the kitchen with director of dietary services E confirmed the dishwasher was a high-temperature dishwasher. Observation on 8/26/25 at 12:25 p.m. in the kitchen by the dishwasher revealed a dietary staff member had started the dishwasher. The external thermometer on the dishwasher during the rinse cycle reached a high temperature of 170 degrees. Review of the provider's Dish Temp log sheet from 7/21/25 through 8/25/25 at 6:30 a.m. revealed: *The final rinse temperature had been documented forty-seven times. *Of those forty-seven documented times the final rinse cycle had been recorded as reaching 180 degrees or higher seventeen times. *From 7/21/25 through 8/25/25 at 6:30 a.m. there would have been 106 opportunities to document the final rinse cycle of the dishwasher. Interview on 8/26/25 at 1:55 p.m. with director of dietary E regarding the dishwasher revealed: *He had been unaware of any requirement for the dishwasher temperature during the final rinse cycle. *He had gotten an email from [name of company] that maintained the dishwasher. The manufacturer's recommendations stated the rinse temp should be 180 degrees. Observation and interview on 8/27/25 at 9:20 a.m. with director of dietary E regarding the	S 106		

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S 106	Continued From page 2 dishwasher revealed: *He ran a test run through the dishwasher. The final rinse cycle reached 172 degrees. *He confirmed it had not reached 180 degrees. *The service company came to the facility quarterly to check the dishwasher unless they were having problems with it. *He agreed there was a problem with the final rinse cycle not reaching 180 degrees. *He agreed they were not following their policy to check the rinse cycle temperature three times a day. *He confirmed they were not following their policy that had stated "Temperatures and sanitizer must be checked three times a day." *They had not consistently checked the final rinse temperature on the dishwasher. Interview on 8/27/25 at 9:25 a.m. with executive director A regarding the dishwasher's final rinse cycle temperature confirmed there was a problem with the dishwasher temperature not continuously reaching 180 degrees. She agreed they were not following their policy. Review of the provider's July 2024 Equipment Specific Cleaning Instructions policy revealed: *Dishwashing Procedures: -"Note - Temperatures and sanitizer must be checked 3 times daily." Review of the manufacturer's recommendations received on 8/27/25 at 9:40 a.m. from executive director A revealed: *Temperatures: -Rinse - (Minimum) 180 degrees.	S 106		
S 165	44:70:02:17 Occupant Protection	S 165		

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S 165	Continued From page 3 Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure one of one sampled resident (5) who smoked and used oxygen had ongoing safe smoking assessments completed. Findings include: 1. Interview on 8/26/25 at 8:30 a.m. with executive director A and registered nurse/clinical services director (RN/CSD) B identified resident 5 was the only resident who smoked and resided in the facility. Observation and interview on 8/26/25 at 2:05 p.m. in resident 5's room regarding her smoking and use of oxygen revealed: *She: -Used a portable oxygen tank when she was out of her room. -Kept the oxygen setting at 3L (an oxygen flow rate of three liters) per her physician's order. -Got her cigarettes and lighter from the staff which was stored on the medication cart. -Smoked one to two cigarettes a day. -Would turn off the portable oxygen tank which was stored on her walker before going outside to smoke. -Used the walker to ambulate with.	S 165	S 165: Resident 5 reassessed for smoking safety. Clinical Services Director completed smoking assessment completed and care plan updated to reflect current smoking status. CSD and ED educated Resident 5 on smoking with oxygen policy & safe smoking practice. CSD to educate clinical staff on residents smoking with oxygen and safe smoking practices. Smoking policy reviewed, no changes made. CSD or designee to complete quarterly smoking safety assessments for residents who smoke and who smoke and use oxygen. CSD will conduct monthly audits of smoking assessments for 6 months. CDS will present audit findings at monthly QAPI meetings.	10/11/25

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S 165	Continued From page 4 -Was able to demonstrate how she turned on and turned off the portable oxygen tank. -Went 30 feet outside of the building "by the yellow flowers she could see from her room window" to smoke. *After she finished smoking she would place the cigarette butt into a smoking container located behind a pillar by the front entrance door. *She would return to the building and give the lighter back to a staff member. *She would turn the portable oxygen tank on when she went back into the building. *She confirmed she had the portable oxygen tank on her walker when she smoked. Review of resident 5's care record revealed: *Her admission date was 3/10/25. *Her 4/21/25 thirty-day Saint Louis University Mental Status (SLUMS) examination score was twenty-three out of thirty which indicated her cognition was mildly impaired. *Her diagnoses included chronic obstructive pulmonary disease (COPD), hypertension (high blood pressure), nicotine dependence (cigarettes), and peripheral vascular disease (reduced blood flow to the extremities). *A physician's order for oxygen continuously at 3 liters (L) per nasal cannula (flexible tubing with prongs that delivers oxygen through the nose). *There was no completed smoking assessment. Review of resident 5's 5/8/25 master care plan revealed: *"Respiratory issues, COPD, oxygen 2L continuously, 3L with her portable concentrator." *It had not included that she smoked. Interview on 8/27/25 at 9:45 a.m. with RN/CSD B regarding resident 5's oxygen use and smoking revealed:	S 165		

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S 165	Continued From page 5 *Resident 5 was on oxygen. *Confirmed resident 5 was a smoker. *She: -Had not completed a smoking assessment and should have. -Acknowledged smoking and oxygen use was a potential fire hazard. *Resident 5's service plan had not included that she had smoked and should have. Review of the provider's August 2025 Smoking Management policy revealed: *"Residents who wish to smoke are assessed by the nurse to determine the individual's ability and willingness to comply with the rules and regulations governing smoking." *"6. Smoking is not allowed in any area where combustible supplies, flammable liquids, gases or oxidizers are in use or stored." *Smoking safety assessment: -"1. All residents who wish to smoke undergo an assessment."	S 165		
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	S 331	S 331: Business Office Director conducted full audit personnel files & LPNs conducted full audit of resident records to identify any other individuals missing timely TB testing. A checklist will be made for onboarding and admission procedures that flags TB testing deadlines. Resident TB testing will be placed in EMR to notify nurses of TB testing due dates. Regional Nurse Director educated nurses on SD requirements of TB testing. Edgewood TB policy reviewed, no changes made. CSD or designee will conduct monthly audits of new employee and resident records for TB testing compliance for 6 months. CSD will present audit findings at monthly QAPI meetings.	10/11/25

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S 331	Continued From page 6 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 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 personnel record review, care record review, interview, and policy review, the provider failed to ensure one of eight sampled employees (C) and one of six sampled residents (2) received a two-step tuberculin (TB) skin test within twenty-one days of employment or admission. Findings include: 1. Review of employee C's personnel record revealed: *He was hired as a maintenance technician on 4/17/23. *There was no evidence to support a TB screening or skin test had been completed in the twelve months prior to employment.	S 331		

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S 331	Continued From page 7 *The documentation revealed the TB skin tests had been completed on 7/25/23 and 8/1/23. *The TB skin tests were completed outside of the twenty-one day requirement. 2. Review of resident 2's care record revealed: *She was admitted on 2/23/24. *There was no evidence to support a TB screening or skin test had been completed in the twelve months prior to admission. *The documentation revealed the TB skin tests had been completed on 4/29/24 and 5/6/24. *The TB skin test were completed outside of the twenty-one day requirement. Interview on 8/27/25 at 1:10 p.m. with registered nurse/clinical services director (RN/CSD) B regarding the TB screenings and testing revealed: *It was the responsibility of the nurses to complete the TB skin tests. -The facility employed one RN and two licensed practical nurses (LPN). *The business office manager would let them know if a new employee needed to have the TB screening and skin test completed. *The TB screening and skin test was a part of the admission process for new residents. *She acknowledged that the skin tests for employee C and resident 2 had not been completed within twenty-one days of employment or admission. *She was not able to offer additional information related to why the tests were completed several months past the required time frame. Review of the provider's August 2025 TB Screening South Dakota - Employee and Resident policy revealed, "Each healthcare employee or resident shall receive an initial TB	S 331		

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S 331	Continued From page 8 risk assessment that is documented and the two-step method of tuberculin test within 21 days of employment or admission. This test will be administered and read by a licensed nurse. Any two documented tuberculin skin tests completed within 12 months prior to the date of admission or employment are considered [a] two-step [test]."	S 331		
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 care record review, interview, and policy review, the provider failed to evaluate and document the care needs of five of the six sampled residents (1, 2, 3, 5, and 6) thirty days after their admission. Findings include: 1. Review of resident 1's care record revealed: *He was admitted on 3/6/23. *His initial evaluation of care needs was completed on 3/6/23. *His thirty-day evaluation of care needs was completed on 5/5/23. 2. Review of resident 2's care record revealed: *She was admitted on 2/23/24. *Her initial evaluation of care need was completed on 2/29/24. *Her thirty-day evaluation of care needs was	S 352	S 352: Clinical Services Director conducted facility-wide audit to identify any other residents missing a 30-day assessment. CSD will pull report of assessment due dates weekly and will complete or delegate assessments. Regional Nurse Director re-educated nurses on assessment requirements and the importance of timely documentation. CSD or designee to complete monthly audits of new admissions to ensure completion of 30-day evaluations x 6 months. Edgewood assessment policy reviewed, no changes made. CSD will present audit findings at monthly QAPI meetings.	10/11/25

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S 352	Continued From page 9 completed on 5/3/24. 3. Review of resident 3's care record revealed: *She was admitted on 6/30/23. *Her initial evaluation of care needs was completed on 6/30/23. *Her thirty-day evaluation of care needs was completed on 8/18/23. 4. Review of resident 5's care record revealed: *She was admitted on 3/10/25. *Her thirty-day evaluation of care needs was completed on 5/8/25. 5. Review of resident 6's care record revealed: *She was admitted on 4/23/25. *Her thirty-day evaluation of care needs was completed on 6/24/25. 6. Interview on 8/27/25 at 9:45 a.m. with registered nurse (RN)/clinical services director (CSD) B revealed she had not completed the thirty-day evaluation of needs for residents 5 and 6 thirty days after their admission to the facility and should have. 7. Interview on 8/27/25 at 10:10 a.m. with RN/CSD B revealed: *She acknowledged that the thirty-day evaluation of needs for residents 1, 2, and 3 had been completed more than thirty days after his or her admission to the facility. *It was her responsibility to complete the evaluation of needs for residents upon admission, thirty days after admission, and annually. *The electronic medical record alerted her when a resident was due for their evaluation and RN/CSD B could print a report out with the information. *She verbalized that the delays likely occurred	S 352		

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S 352	Continued From page 10 due to the need for her to provide nursing coverage in other Edgewood facilities in the local area. 8. Review of the provider's August 2025 Assessment policy revealed: *"Periodic reassessments are conducted to verify the resident's condition and to determine if the resident meets continued stay criteria. Reassessments include the components identified under the admission process." *"Reassessments are conducted at least annually or as required by state regulations and with any significant change in the resident's condition by the registered nurse."	S 352		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration.	S 685	S 685: Resident #6 received physician's order for self-administration of insulin. CSD completed review of all resident charts to identify all residents who self-administer medications. All identified residents were reviewed for valid physician orders for self-administration & documentation of quarterly assessments. Quarterly self-administration assessment due dates tracked by EMR. Admission checklist updated to include verifying self-administration orders. Edgewood self-administration policy reviewed, no changes made. CSD or designee to audit self-administration documentation monthly for 6 months. CSD will present audit findings at monthly QAPI meetings.	10/11/25

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S 685	Continued From page 11 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, care record review, interview, and policy review, the provider failed to ensure safe self-administration of medication practices for two of two sampled residents (3 and 6) who did not have: *A physician's order to self-administer insulin for one of one sampled resident (6). *Quarterly self-administration assessments for the medication that resident 3 stored in her room and utilized. Findings include: 1. Observation on 8/27/25 at 8:00 a.m. with certified medication aide (CMA) D during medication administration for resident 6 revealed: *CMA D: -Removed the Humalog insulin pen for resident 6 from the top drawer of the medication cart. -Placed a new needle onto the tip of the insulin pen and primed it to 2 units. -Went into resident 6's room and handed her the insulin pen. *Resident 6 dialed the insulin pen to 4 units and self-administered the insulin. *CMA D took the insulin pen back to the medication cart, removed the needle, and placed the insulin pen back into the top drawer of the medication cart. Review of resident 6's care record revealed: *She was to receive Humalog insulin twice a day. *Her Saint Louis University Mental Status (SLUMS) evaluation score completed on 8/16/25 was twenty-four out of thirty, which indicated mild cognitive impairment. *The last self-administration of medication assessment had been completed by a registered nurse on 8/21/25.	S 685		

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S 685	Continued From page 12 *There was no physician's order for her to self-administer insulin. Interview on 8/27/25 at 1:00 p.m. with registered nurse/clinical services director (RN/CSD) B confirmed there was no physician's order for resident 6 to self-administer insulin and should have been. 2. Review of the care record for resident 3 revealed: *Her Saint Louis University Mental Status (SLUMS) evaluation completed on 7/7/25 was nineteen out of thirty, which indicated cognitive impairment. *On 6/12/24, a physician's order was obtained to allow her to administer Cortisone 10 - 1% hydrocortisone to her skin three times a day as needed for itchiness and to keep at her bedside. *A self-administration of medication assessment was not completed until 8/21/25 by RN/CSD B stating the resident was safe to self-administer the hydrocortisone cream and to keep it in her room. 3. Interview on 8/27/25 at 10:10 a.m. with RN/CSD B regarding resident 3's self-administration of medication assessment revealed she: *Confirmed that resident 3's primary care provider had provided the order to self-administer the hydrocortisone cream on 6/12/24 and the resident had been using it at her bedside from that date. *Was going through the resident's medication records and found that resident 3 had not had a self-administration of medication assessment completed when the medication was ordered from the physician. -She completed the assessment on 8/21/25.	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67578	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 685	Continued From page 13 4. Review of the provider's August 2025 Self-Administration policy revealed: *"All residents must be evaluated using the self-administration assessment and deemed competent by a registered nurse to self-administer medications". -It did not identify a frequency for the self-administration of medication assessments. *"Obtain signed approval (from a physician or other legal practitioner) for the resident to self-administer the medication(s) prescribed for him/her, if required by state regulations..."	S 685		