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 12/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 12/30/24. The area surveyed was resident neglect. The Victorian Assisted Living was found not in compliance with the following requirements: S337, S352, S405, S415, and S838.	S 000		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and job description review, the provider failed to ensure: *One of one director of clinical operations (DCO)/licensed practical nurse (LPN) (C) had clarified one of one closed record sampled resident's (1) physician's order for oxygen. *One of one unlicensed medication aide (UMA) (E) had rechecked one of one closed record sampled resident's (1) oxygen saturation level (percentage of oxygen in the blood) after that saturation level was identified as having been outside of an acceptable range. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was hospitalized from 9/20/24-9/30/24 after a fall that resulted in left-side rib fractures. -His other diagnoses included: mild cognitive	S 337		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive Director (X6) DATE 1-28-2

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S 337	Continued From page 1 impairment, chronic obstructive pulmonary disease (COPD), major depression, anemia, chronic respiratory failure, and impaired functional mobility. *He was admitted to the facility on 9/30/24. *The discharging hospital's After Visit Summary (AVS) for resident 1 printed on 9/30/24 at 10:58 a.m. revealed: *The resident was hospitalized from 9/20/24 through 9/30/24 after a fall which resulted in closed, left-side rib fractures. -His other diagnoses included mild cognitive impairment, chronic obstructive pulmonary disease (COPD), major depression, anemia, and chronic respiratory failure. *The AVS list of resident 1's discharge medications included: "oxygen gas. Commonly known as: O2. 2 L [liters]/min [per minute] by nasal cannula route continuously." -Beside the oxygen order the following was hand-written:"4.5 L @ Hospital. Goal 88-93% [oxygen saturation level]." *That discharge medication list was electronically signed as having been reviewed and acknowledged by DCO/LPN C. *Emergency medical services (EMS) was contacted after the resident had an unwitnessed fall in the early morning hours of 10/1/24. Cardiopulmonary resucitation was initiated by EMS. The resident expired 10/1/24. Telephone interview on 12/30/24 at 3:45 p.m. with DCO/LPN C revealed: *She had electronically signed that AVS on 9/30/24 before resident 1 was admitted to the facility. *She was aware of the hand-written information on the AVS beside the oxygen order regarding resident 1's oxygen needs during his hospital stay.	S 337	In reference to tag S 337 any admission receiving oxygen, orders will be verified by the nurse with the physician and documented prior to admission. This is effective 1/16/25. In reference to tag S 337 a full time RN will begin employment effective 1/20/25 and will be in house. All admissions will be conducted through this nurse. Effective 1/16/25 Nurse D will perform any new admissions until the full time RN begins employment. Any admissions will only admit on days Nurse D is present. In reference to tag S 337 any resident already receiving oxygen will be audited weekly for a month to ensure orders for liter flow coincide with what the resident is receiving. This will begin 1/17/25. This audit will then be conducted monthly for six months beginning 2/18/25 and end 8/18/25. Nurse D or DON will perform audits. Administrator A will initial audits.	02/13/2025

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S 337	Continued From page 2 *The oxygen order that was entered in resident 1's electronic medical record (EMR) at the facility was: "Oxygen 2 L/minute via Nasal Cannula route continuously." -She had not contacted the resident's medical provider to have clarified what the resident's oxygen order should have been. 2. Review of resident 1's closed record revealed: *Resident 1's pulse oximetry reading (a test used to measure the oxygen saturation level in the blood) taken by UMA E on 9/30/24 at 2:45 p.m. was 80%. -A normal resting oxygen saturation level was between 95% and 100%. *There was no documentation to support the resident's oxygen saturation level was rechecked after it was initially taken to have determined if it remained outside of the acceptable parameters. Interview on 12/30/24 at 4:00 p.m. with UMA E and administrator A regarding resident 1's oxygen saturation reading above revealed: *The resident was using 1-2 liters of oxygen at the time UMA E had taken that reading. *She thought a normal oxygen saturation level was "90% or above." -She had not retaken a pulse oximetry reading to have determined if the resident's oxygen saturation reading had remained lower than normal but she should have. *She had not notified a nurse of the resident's low oxygen saturation reading. Review of the provider's 9/28/21 Director of Nursing (DON) job description revealed: *Responsibilities and Authorities: -"A. The DON is accountable to the facility Administrator and is responsible to oversee all resident care and medical function of the facility,	S 337	In reference to tag S 337 all UMA's and RCA's will receive written and verbal education in regards to vitals, parameters and when and who to report to if not in parameters by Nurse D or DON. Included in the education will be when to take vitals/rechecking vitals. Signed education will be completed on all UMA's and RCA's by 1/30/25. Administrator A will initial off on the education.	1/30/25

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S 337	Continued From page 3 for implementation of all medical policies and procedures, and to ensure all residents received the highest level of services in accordance with State regulations." Review of the 7/31/24 Medication Technician (UMA) job description revealed: "A Medication Technician [Med Tech] is a primary provider of resident care and delivery of medications. A Med Tech promotes the physical, personal and emotional well-being of each resident..."	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 closed record review, interview, and review of the director of nursing job description, the provider failed to evaluate and document resident care needs upon admission for one of one closed sampled resident (1). Findings include: 1. Review of resident 1's closed electronic medical record (EMR) revealed: *He was admitted on 9/30/24 and expired on 10/1/24. *There was no documentation to support his initial care needs evaluation was completed. *Emergency medical services (EMS) was contacted after the resident had an unwitnessed	S 352	In reference to tag S 352 effective 1/17/25 all admissions will be audited. Nurse D or DON will sign off that initial assessment and other assessments are completed upon admission and entered into PCC. A form has been created to track new admissions and assessments. The ED will check all admissions to ensure assessments are completed and entered on day of admission.	02/13/25

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S 352	Continued From page 4 fall in the early morning hours of 10/1/24. Cardiopulmonary resucitation was initiated by EMS. The resident expired 10/1/24. Interview on 12/30/24 at 3:00 p.m. with administrator A revealed: *Initial care needs evaluations were completed by either registered nurse (RN) D or director of clinical operations (DCO)/licensed practical nurse (LPN) C. -Those evaluations were to be documented in the resident's EMR the day of a resident's admission. *She thought DCO/LPN C had completed resident 1's initial care needs evaluation but there was no documentation to support that had occurred. Telephone interview on 12/30/24 at 3:50 p.m. with DCO/LPN C regarding resident 1's initial care needs evaluation revealed: *She was responsible for completing that evaluation but it was not done. -She had not notified either administrator A or RN D she had not completed the evaluation. *She confirmed she had not completed a service plan for the resident. Review of the provider's 9/28/21 Director of Nursing (DON) job description revealed: *Responsibilities and Authorities: "A. The DON is accountable to the facility Administrator and is responsible to oversee all resident care and medical functions of the facility,..." *DON duties included: "B. 3. Initiates and signs the required assessments and care plan of new resident in accordance with state regulations." -"5. Completes the required assessments in a timely manner, on each resident to determine level of care and care requirements."	S 352	In reference to tag S 352 Effective 1/17/25 Nurse D or DON will ensure a new admission has a service plan in place on the day of admission. Administrator A will audit each new admission on day of admission to ensure a service plan is in place and initial audit. In reference to tag S 352 Nurse C will provide education to Nurse D and new DON by 2/13/25. The education will include required assessments and service plan upon admission. Also education regarding verifying oxygen orders Education will be signed by both nurses. Administrator A will sign off on the education	02/13/25

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S 405	Continued From page 5	S 405		
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, job description review, and policy review, the provider failed to develop an individualized resident care plan to reflect the needs of one of one closed record sampled resident (1). Findings include: 1. Review of resident 1's closed electronic medical record (EMR) revealed: *He was admitted on 9/30/24 and expired on 10/1/24. *There was no documentation to support he had an individualized service plan. *Emergency medical services (EMS) was contacted after the resident had an unwitnessed fall in the early morning hours of 10/1/24. Cardiopulmonary resucitation was initiated by EMS. The resident expired 10/1/24. Interview on 12/30/24 at 3:00 p.m. with administrator A regarding resident 1's service plan revealed: *Service plans were to be completed by either registered nurse D or director of clinical operations (DCO)/licensed practical nurse (LPN) C on the day a resident was admitted to the facility.	S 405	In reference to tag S 405 effective 1/17/25 Nurse D or DON will ensure the new admission has an individualized service plan in PCC on day of admission. Administrator A will check all new admits for a service plan and initial the audit.	02/13/25

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S 405	Continued From page 6 -She thought DCO/LPN C had completed resident 1's service plan but confirmed there was no documentation to support that had occurred. Telephone interview on 12/30/24 at 3:50 p.m. with DCO/LPN C regarding resident 1's service plan revealed failing to document an evaluation of resident 1's initial care needs in his EMR prevented a service plan from being completed for him. Review of the provider's 9/28/21 Director of Nursing (DON) job description revealed: *Responsibilities and Authorities: "A. The DON is accountable to the facility Administrator and is responsible to oversee all resident care and medical function of the facility,..." *DON duties included: "B. 3. Initiates and signs the required assessments and care plan of new resident in accordance with state regulations." Review of the provider's undated Day of Admission/Move-In policy revealed: *"1. The Administrator/designee coordinates the following on move-in day to ensure appropriate resident care:"\ -"b. The service plan is completed."	S 405		
S 415	44:70:05:03 Resident Care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep	S 415	In reference to tag S 415 Admissions will only be admitted under an on site nurse effective 1/17/25. Nurse D or DON will ensure all assessments and service plan are completed on day of admission. An audit form has been created for each admission. Administrator will sign the audit.	02/13/25

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S 415	Continued From page 7 skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to follow their falls policy by addressing precluding factors, details, and actions taken for two of two unwitnessed falls of one of one closed record sampled resident (1). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was hospitalized from 9/20/24-9/30/24 after a fall that resulted in left-side rib fractures. -His other diagnoses included: mild cognitive impairment, chronic obstructive pulmonary disease (COPD), major depression, anemia, chronic respiratory failure, and impaired functional mobility. *He was admitted to the facility on 9/30/24. *The resident had nearly fallen in the facility's parking lot when he arrived on the day of his admission. -Resident 1 had two subsequent unwitnessed falls within 24 hours of his admission while in the facility. Review of resident 1's 9/30/24 Incident Report revealed: *It was completed by an unlicensed medication aide (UMA). *At 9:50 p.m. staff responded to his call light and found him on the floor in his room. *There was no indication on that Report: -If the resident had pressed his call light before or after he had fallen. -In what position the resident was found "on the ground between his bed and recliner."	S 415		

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S 415	Continued From page 8 -If any potential hazards or fall risks had been identified by staff that may have contributed to the fall. -If staff had offered to assist the resident to use the bathroom before helping him back to bed. -What fall prevention interventions had been implemented as a result of that fall. -If any post-fall resident monitoring was implemented. *A progress note regarding that fall had indicated: -The resident's oxygen was on but it was unclear if that meant he was wearing it at the time of the fall or not. His oxygen saturation immediately following the fall was 80% but increased to 90% 30 minutes post-fall. -The resident had worn no footwear at the time of the fall and he had requested his room light remain on after that fall occurred. *There was no documentation to support any nurse acknowledgement of that fall. Review of resident 1's 10/1/24 Incident Report revealed: *It was completed by a UMA. *On 10/1/24, he was checked on by staff at 3:20 a.m. and was found unresponsive, not breathing, and laying by his bed on the floor. *There was no indication on that Report: -If the resident's call light was accessible. -In what position he was found "laying by his bed." -How staff had "Tried waking him." -If the resident's oxygen was on or if he was wearing it. -If the light in his room had been left as he had requested after his first fall. -If any post-fall prevention interventions after his first fall had been implemented. -When the resident was last checked on by staff before he was found unresponsive.	S 415	In reference to tag S 415 all UMA's and RCA's will receive verbal and written training in regards to fall protocol and incident reports. Trainings will be signed by these staff members by 1/30/25. In reference to S 415 a mock fall drill will be done weekly for a month starting 1/24/25. The fall drill will then be performed monthly for six months. Staff will be required to explain the fall protocol and complete an incident report. The reports will be reviewed and education provided. In reference to tag S 415 all incident reports will be reviewed by the ED and DON. If the incident report is not complete or needing additional information it will be returned to that staff member, reviewed and they would update.	02/13/25

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S 415	Continued From page 9 Interview on 12/30/24 at 5:00 p.m. with administrator A regarding resident 1's fall documentation above revealed: *She had signed off on both of those reports indicating she had reviewed them but she had known the content in those reports was less than she had expected. -She had not returned the reports to either staff who had written them and requested additional information to ensure they were complete but she should have. *Nursing services were provided by director of clinical operations (DCO)/licensed practical nurse (LPN) C. -DOC/LPN C resided out of state but she was available by phone, text, e-mail, fax, or video. -LPN C resided locally, was part-time and worked two days a week. *Administrator A confirmed there was a lack of documentation by either nurse that would have supported their involvement with resident 1's care after he was admitted to the facility. *Emergency medical services (EMS) was contacted after the 10/1/24 unwitnessed fall. Cardiopulmonary resucitation was initiated by EMS. The resident expired 10/1/24. Review of the provider's undated Falls policy revealed: "7. An electronic incident report is completed in the EMR. The electronic incident report is inclusive of the following: details of the event, injuries sustained from event, factors of the event (inclusive of predisposing environmental factors, predisposing physiological factors and predisposing situations or RCA [root cause analysis]), witnesses, actions taken, notes and signatures."	S 415		

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S 838	Continued From page 10	S 838		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one closed record sampled resident (1) received care that contributed to his overall quality of life by ensuring: *Professional standards of care were followed related to his use of oxygen. *An initial evaluation of his care needs was completed on the day of his admission. *An individualized resident service plan was developed on the day of his admission. *Two of two unwitnessed falls that occurred within 24 hours of his admission had been thoroughly investigated. *Safety and wellness checks were implemented at the time of his admission and documented. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was hospitalized from 9/20/24 through 9/30/24 after a fall that resulted in left-side rib fractures. -His other diagnoses had included: mild cognitive	S 838		

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S 838	Continued From page 11 impairment, chronic obstructive pulmonary disease (COPD), major depression, anemia, chronic respiratory failure, and impaired functional mobility. *He was admitted to the assisted living facility on 9/30/24 from the hospital. *He had nearly fallen in the parking lot upon entering the facility on the day of his admission. *He had two unwitnessed falls that occurred within 24 hours after his admission. *On 10/1/24, he was checked on by staff at 3:20 a.m. and was found unresponsive, not breathing, and laying by his bed on the floor. -Emergency medical services (EMS) was contacted. Cardiopulmonary resucitation was initiated by EMS. The resident expired 10/1/24. Interviews on 12/30/24 at 2:45 p.m. and again at 4:45 p.m. with administrator A and administrative assistant (AA)/unlicensed medication aide (UMA) B regarding the safety of newly admitted residents revealed: *Caregivers were expected to have visually checked on new residents on a regular basis after they were admitted. -The frequency of those checks was individualized and was generated from the documentation in the initial evaluation of the resident's care needs completed by the nurse on the day of a resident's admission. *A wellness check "task" was populated in a resident's EMR based on that initial evaluation information. Caregivers documented their visual resident checks on that task form. *AA/UMA B confirmed resident 1 had no wellness check task documentation because an initial nurse evaluation of his care needs was not completed on the day of his admission. *Given resident 1's fall history administrator A expected wellness checks to have been	S 838	In reference to tag S 838 All admissions will be reviewed and assessed prior to admission by Nurse D or the DON. Admissions will be audited by the nurse and Administrator A to ensure assessments and service plans are initiated on day of admission. In reference to tag S 838 Admission medical history will be reviewed and if there are safety concerns regarding falls Nurse D or DON will ensure tasks for safety checks are in place day of admission. Safety checks will also be on the audit form. Administrator A will sign off on the audit form. The audit form will include if the safety checks have been documented and implemented.	02/13/25

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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 838	Continued From page 12 documented no less than every two hours. -AA/UMA B told staff on 9/30/24 they were expected to document wellness checks for resident 1 no less than every two hours. *Nursing services were provided by director of clinical operations (DCO)/licensed practical nurse (LPN) C. -DOC/LPN C resided out of state but she was available by phone, text, e-mail, fax, or video. -LPN C resided locally, was part-time and worked two days a week. *Administrator A confirmed there was a lack of documentation by either nurse that would have supported their involvement with resident 1's care after he was admitted to the facility. Review of the provider's undated Day of Admission/Move-In policy revealed: "The assigned caregiver checks with the newly placed resident frequently for the first 24 hours of placement, unless otherwise requested by the resident." Review of the provider's undated Safety policy revealed: "Through assessments and history of falls we will determine the number of safety checks for each resident and have it specialized for each individual's needs." 2. Refer to the findings in S337, S352, S405, and S415.	S 838		