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
	47881	A. BUILDING: ___ B. WING ___	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONDEROSA LODGE SENIOR LIVING	**7400 S LOUISE AVE SIOUX FALLS, SD 57108**

(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 from 1/15/25 through 1/16/25. Areas surveyed included resident abuse and neglect, admission, transfer and discharge rights, quality of life, physical environment, administration, and personnel. Ponderosa Lodge Senior Living was found not in compliance with the following requirements: S202, S296, S415, S800, S838, and S866.	S 000	This Plan of Correction is not to be interpreted as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies dated 1/16/2025. It is a submission of our ongoing efforts to comply with regulatory requirements. We have outlined specific actions in response to identified concerns. We remain committed to the delivery of quality health care services and will continue to make changes and improvements in line with that objective.	2/28/25
S 202	44:70:03:02 General Fire Safety At least two personnel must be on duty at all times, unless the department has approved a staffing exception requested by the facility. In a multilevel facility, at least one personnel must be on duty on each floor containing occupied beds. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, observation, record review and license review, the provider failed to maintain staffing on each floors' units of the building at all times. Findings include: 1. Interview on 1/15/25 at 11:45 a.m. with executive director (ED) A and health services director (HSD) B confirmed they had 51 assisted living residents on three separate floors of the facility: *The first floor of the facility had wings A and B in the front of the facility connected by a hallway to wing C in the rear of the facility. *The second floor of the facility had wings A and B at the front of the facility. *The second floor's wing C was at the rear of the facility and was not accessible to wings A and B.	S 202	S202. General Fire Safety 1. Community will maintain a minimum of three (3) staff based on regulation indicating this is the minimal staffing required. Positions have been posted. 2. ED, or designee, will review schedules to ensure appropriate staffing is in the community weekly x 4 weeks, biweekly x 4 weeks, then monthly until compliance is reached.	2/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Martina Castle TITLE Executive Director (X6) DATE 2/14/25

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*HSD B stated they staffed two staff members to work the overnight shift (10:00 p.m. through 6:00 a.m.).

2. Observation on 1/15/25 at 12:01 p.m. during the facility tour revealed:
*The second floor's C wing was comprised of studio and one-bedroom apartments with assisted living residents on that wing accessible by an elevator and stairs from the first floor's C wing.
*The first floor's C wing was accessible by a hallway that led to the first floor's A and B wings.
*The first floor's A and B wing had elevators and stairs that led to the second floor's A and B wing.
*The second floor's A and B wing were not connected to the building's second floor C wing.

2. Interview on 1/15/25 at 1:00 p.m. with certified medication aide (CMA) D revealed she:
*Had worked at the facility for one month.
*Worked the overnight shift.
*Stated two staff worked the overnight shift.
-One staff member was assigned to the C wings on both the first and second floors.
-One staff member was assigned to the A and B wings on both floors.
*Agreed that there were times during the overnight shift when units had no staff as there were two separate second floors.

3. Interview on 1/15/25 at 5:06 p.m. with CMA C revealed:
*She had worked at the facility for two years.
*She worked the overnight shift from 6:00 p.m. to 6:30 a.m.
*There were two staff that worked the night shift.
-One staff worked the C wings on both the first and second floors.
-One staff worked the A and B wings on both

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S 202	Continued From page 2 floors. *Agreed that there were times during the overnight shift when units had no staff as there were two separate floors for each of the staff assigned. 4. Review of the provider's Assisted Living Center License revealed: *They had been approved for additional services for cognitively impaired residents. *They had been approved to accept: -Physically impaired residents. -Residents incapable of self-preservation. -Residents dependent on supplemental oxygen. -Residents who elected hospice. *They had a provision for the assisted living units in the apartment complex that stated those units must be staffed at all times.	S 202		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication	S 296	Going forward staff trainings including those for indidvidualized needs will be documented and maintained in staff training Binder. Training documentation will include at minimum topics covered, time of inservice and staff that attened. Copies of attendance sheets will be maintained in individual staff files This binder will be audited by ED or designee to ensure completion weekly for one month, biweekly for one month and monthly until compliance is acheived.	2/28/25

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S 296	Continued From page 3 techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). 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 direct care staff had received education based on individualized resident's needs following an incident between one of one sampled (1) resident and a male independent living (IL) resident (4) according to the provider's action plan and to ensure resident safety. Findings include: 1. Review of the provider's South Dakota Department of Health (SD DOH) facility-reported incidents (FRI) submitted on 12/28/24 at 6:54 p.m. and 12/31/24 at 5:59 p.m. for a suspicion of resident to resident abuse by IL resident 4 to resident 1 revealed: *The event occurred on 12/27/24 at 8:00 p.m. in resident 1's room. *The brief explanation included: -Health Services Director (HSD) B was contacted after a caregiver and certified medication aide	S 296	ED/Designee will be providing Abuse and Neglect Training for all staff. This will be completed by 2/28/25.ype text here	2/28/25

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(CMA) had answered resident 1's call pendant and found the male resident on top of resident 1 in her room.
-Resident 1 was asking for help.
-The CMA attempted to remove IL resident 4 away from resident 1 and he became combative and aggressive.
-IL resident 4 attempted to push the CMA out of the way and out of the room but the CMA was able to get him back to his own room.
-Both residents were clothed.
-The CMA checked on resident 1 and notified health services director (HSD) B who contacted executive director (ED) A.
-HSD B and ED A arrived at the facility, spoke with resident 1, and called 911.
-A law enforcement report and case was filed.
-Resident 1 admitted to law enforcement that she and IL resident 4 had a close friendship.
--She had invited him over for dinner, movies, and a drink.
--During the movie things escalated and IL resident 4 would not take no for an answer so she pushed her call pendant for help.
-Law enforcement interviewed both residents.
-Resident 1 did not press charges and law enforcement recommended both residents stay away from one another.
*The investigation conclusion included:
-"No charges filed, police recommended both residents stay away from each other and staff will enforce this to [the] best of ability. Safety checks every two hours has been placed on female assisted living resident's plan of care, she has been educated to push pendant if male independant [independent] resident knocks on door or attempts to contact with her. Staff has been educated to re-direct male resident back to his apartment if needed. If male resident does not comply then staff has been directed to contact

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S 296	Continued From page 5 911 and notify [HSD B] and [ED A] immediately. Independant [independent] resident's family (Son) [name] has been notified of situation..." Interviews and record review on 1/15/25 and 1/16/25 during the survey identified there had been no documented training for direct care staff related to the above incident. HSD B and ED A indicated they had educated multiple staff members verbally, but that was not documented. They were aware of the requirement for staff training based on individualized resident care needs based on residents who were accepted and retained in the facility. Refer to S838. Review of the provider's 1/13/23 Personnel policy related to staff training included "Any additional healthcare employee education necessary based on the individualized resident care needs provided by the healthcare employees to the residents who are accepted and retained in the facility."	S 296		
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 skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not	S 415	Regional Director of Health Services will review documentation standards and practice with HSD. This was completed on 2/7/25. HSD will provide documentation and alert charting training to all clinical staff regarding incidents and changes in condition by 2/28/25. As indicated all clinical staff which will include med aides, resident caregivers and other nursing staff.	2/28/25

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S 415	Continued From page 6 met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to ensure the individual care needs for one of one sampled resident (1) had been assessed and documented by licensed nursing staff related to her health status, falls, and changes in condition. Findings include: 1. Review of resident 1's care record revealed: *She had admitted on 5/13/24. *Her diagnoses included: neurocognitive disorder, history of seizures, alcohol dependence, history of a traumatic brain injury, anxiety, depression, and ataxic gait (uncoordinated and unsteady walking). *She had Saint Louis University Mental Status (SLUMS) Cognitive Evaluation Screenings on the following dates: -On 5/8/24 and 6/7/24 her scores were twenty-eight out of thirty which indicated she had no cognitive impairment. -On 7/23/24 her score was twenty-five out of thirty which indicated she had no cognitive impairment. -On 12/28/24 her score was twenty-two out of thirty which indicated she had mild cognitive impairment. *Her Fall Risk evaluations on 5/8/24 and 7/17/24 indicated she was at low risk for falls. Review of resident 1's progress notes from 5/26/24 through 1/15/25 by the caregivers, CMAs, and licensed nurses included the following: *On 8/9/24 at 8:45 p.m. she had an unwitnessed fall in her room trying to get undressed to shower. She had a scrape on her buttocks and no other injuries. -The next note was not until 8/14/24 and had not supported follow up regarding her fall. *On 9/3/24 at 10:27 a.m. she had returned to the	S 415	HSD or designee, will review all observation notes for completeness at least twice a week for 4 weeks and then at least weekly X4 weeks or until compliance is acheived. Ed, or Designee will review documentation of observation notes and incidents to ensure timely interventions and follow up is completed at least twice a week for 4 weeks and then weekly until compliance is acheived. This includes HSD notes. Regional Director of Health Services will do a random review of observation notes monthly3 months and then quarterly until compliance is acheived.	

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facility from a leave of absence with a bruise noted on the left side of her face above her eye. She was unsure of how or when it happened.
-The next note was not until 9/26/24 which had not supported follow up to the injury.
*On 10/28/24 at 5:28 a.m. staff noted a bump on her forehead. The resident reported she fell around 8:00 a.m. on 10/27/24 but had not told anyone. She stated she had tripped on a cord and hit her head on the floor.
-The next note was on 10/30/24 at 1:46 p.m. which indicated she had been found on the floor in her bedroom doorway.
*On 11/7/24 at 4:09 p.m. she was sitting in her vehicle in the parking garage with it running. The note included that staff were aware she did not have a valid driver's license, she had recently sustained a left ankle fracture and was supposed to be non-weight bearing for six to eight weeks, and her wheelchair was located in front of the vehicle. She reported to staff she was reading mail and letting her car run to keep the battery from dying. Staff escorted her back to her apartment.
-There had been no indication of when that left ankle fracture had occurred in the notes prior to that or assessments related to it.
*On 11/16/24 at 1:32 p.m. she had been found on the floor in her room and had a small bump on the back of her head. She refused to see a provider for evaluation.
-The notes had not included follow up assessment of her condition.
*On 11/17/24 at 5:14 p.m. a note indicated IL resident 4 had been in the resident's room drinking beer with her. Staff reminded her about her falls.
*On 11/23/24 at 9:00 p.m. staff noted the resident appeared to be under the influence of alcohol and had a large bottle of alcohol on the counter in her

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room.
*On 11/29/24 at 6:38 a.m. staff noted both of the resident's hands were very swollen and bruised.
-There was no indication of this being a concern prior or if the resident reported what had happened.
*On 11/29/24 at 1:20 p.m. the nurse assessed her hands and the resident denied falling. The resident's Veteran's Affairs (VA) case manager was notified and planned to see the resident on 12/2/24.
-The next note was not until 12/22/24 and it had no indication of her health status or what had occurred with her hands.
-That note was that she was going out on a leave and forgot to take her medications with her.
*On 12/28/24 at 1:00 a.m. and 3:08 a.m. notes of "Safety check, asleep, door locked."
*On 12/28/24 at 8:03 p.m. a late entry note of "situation between resident and IL male resident, resident had invited male resident over for dinner and movie. Male resident began making unwanted advances, resident pushed pendant. Med aide got male resident to leave room. Notified this HSD who notified ED. Police contacted. Report filed. State report filed."
-There was no mention of her representative or physician having been notified.
*On 12/30/24 at 9:24 a.m. note of:
-"[Resident] put on pendant for assistance. Staff responded and [resident] was asking for help getting [IL resident 4] off of her. Staff assisted him off, with some resistance, and [IL resident 4] left room. HSD, ED, police all notified."
-"Staff will provide spot checks each shift to make sure resident is safe."
*On 1/1/25 at 1:49 a.m. and 5:44 a.m. notes of "Safety check, door locked, asleep."
*On 1/2/25 at 12:08 a.m. "Safety check, resident says, [IL resident 4] let himself into her room,

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when she had just got back from checking her clothes. He wouldn't leave so she asked him to walk the dog and pressed her button, waited for Resident to get her dog back, walked with her to the laundry room, to check how long her clothes have [left to be done], got her clothes, and checked her room to make sure it was just her, locked her door."
*On 1/2/25 at 5:49 p.m. "Resident pendant alerted staff. [IL resident 4] knocking on her door. [IL resident 4] re-dierected [re-directed] back to his apartment. This HSD notified and sdpoke [spoke] with [IL resident 4] and reminded him he may not have any contact with resident [1]."
*On 1/3/25 at 5:54 a.m. "Checks at 2 and 4 resident woke up to me knocking at door and unlocking to see if she was alright. Resident was alone in room and said no one had bothered her all night."
*On 1/5/25 at 1:51 a.m., 3:35 a.m., and 11:40 p.m. "Safety check, door locked, asleep."
*On 1/6/25 at 4:42 p.m. the resident had an unwitnessed fall and her wrist appeared deformed and swollen. HSD B contacted her VA case manager and sent her to the emergency room. HSD B was notified that the resident was transferred to a different hospital and was admitted.
-There were no notes that indicated the resident had returned to the facility or follow up to her wrist injury.
*On 1/8/25 at 6:30 a.m. "Resident had put on pendant and stated [IL resident 4] was knocking and ringing her door bell and that she did not open the door. Writer ensured that the door was locked when leaving the room."
*On 1/10/25 at 12:51 a.m., 3:51 a.m. and 10:07 p.m. and 1/11/25 at 1:42 a.m. notes all stated "Safety check, door locked, asleep."
*On 1/13/25 at 3:03 a.m. "This HSD was

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contacted by staff [CMA D and CMA E] am at 135 that when they went to answer pendant and found resident on floor with blood around her. [IL resident 4] was standing in the corner of room closing the blinds. Staff had [IL resident 4] return to room, they did note blood on his clothes. HSD informed staff to leave residenton [resident on] floor until police arrive. HSD contacted 911 and officers arrived right after HSD all entered resident room staff was with resident and residnet [resident] still on floor naked with old shower curtain covering her. police then took over scene. ED contacted and wasa [was] also on scene."
-There was no mention of her representative or physician being notified, her report of being touched sexually, or additional details that supported what had occurred during that incident.
*The above 1/13/25 note was the last progress note in her record.

Review of resident 1's current care plan included:
*"Safety checks per policy."
*"Spot checks" three times daily at 10:00 a.m., 7:00 p.m. and 12:15 a.m. with a date of 12/27/24 and a note of "Check on resident to see that she is safe in her apartment."
*"Safety: Shift Wellness Check" daily, with no time specified, and a note of "Safety check to ensure that [room number of IL resident 4] is not following or harrassing [harassing] resident. Redierct [redirect] [IL resident 4] back to apartment and notify [HSD B] or [ED A]."
*There was no mention of falls, injuries related to falls, or other concerns as identified in the progress notes.

Interview on 1/16/25 at 9:25 a.m. and again at 1:50 p.m. with HSD B and ED A regarding nursing assessments and documentation revealed:
*HSD B was currently the only licensed nurse for

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the building.
*Previously there had been another licensed nurse who assisted with nursing related assessments and documentation.
-That other nurse had left in December 2024 and they had not been able to hire a replacement yet.
*HSD B confirmed the information in the progress notes above was the only documentation in the resident's record related to her falls, health status, and changes in condition.
-Other documentation related to falls or events was listed in internal incident reports and not part of the resident's record.
*HSD B confirmed the above notes had not supported details and follow up related to the resident's falls, nursing assessments, and her health status.

Review of the provider's 5/13/23 Fall Management and Post Fall Investigations policy revealed:
*"Fall interventions are documented in the resident individualized service/care plan."
*"The resident responsible party and physicians are notified of falls."
*If a resident fell when a licensed nurse was on duty they would have evaluated the resident for injuries.
*If a resident fell when a licensed nurse was not on duty the staff would have notified the nurse immediately.
*The HSD or designee would update the service/care plan.
*Falls should have been investigated, reported, and documented using the incident report and post fall tools.
-There was no mention of documenting in the resident's medical record in addition to those areas.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONDEROSA LODGE SENIOR LIVING	**7400 S LOUISE AVE SIOUX FALLS, SD 57108**

(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 415	Continued From page 12 Review of the provider's revised 3/10/23 Documentation Standards - Resident Health Record policy revealed: *The policy was to maintain a record that reflected an accurate and progressive condition of the resident, including care provided, interventions and outcomes, and was in a manner consistent with current standards of practice. *Documentation entries should have been: -Chronological. -Objective in nature and factual. -Direct observations and observations reported by the resident or other staff members. -Made by appropriately trained staff members authorized to document in the progress notes. -Completed as soon as possible after an event had occurred. *Late entries were discouraged.	S 415		
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	S 800	Hsd or designee will review emergency contacts for all assisted living residents to ensure provider and emergency contact/responsible parties information is accurate. HSD or designee will retrain staff on notifications of providers and emergency contact/responsible party and documentation of the same. ED or designee will review all observbations and incidents notes with focus on changes in condition to ensure appropriate notifications were done at least twice a week for 4 weeks and then weekly until compliance is acheived.	2/28/25 2/28/25 2/28/25

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S 800	Continued From page 13 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 notification to the practitioner and representative had occurred timely and documentation of that notification was completed for one of one sampled resident (1) related to falls and changes in her condition. Findings include: 1. Review of resident 1's care record revealed: *She had admitted on 5/13/24. *Her diagnoses included: neurocognitive disorder, history of seizures, alcohol dependence, history of a traumatic brain injury, anxiety, depression, and ataxic gait (uncoordinated and unsteady walking). *In her admission records for the facility under the responsible party contact information she had listed her primary contact as her brother and her secondary contact as her sister. -Her primary practitioner was a physician at Veteran's Affairs (VA) health services. -She had signed for receipt of the resident's rights information which included having a person appointed to act on her behalf and that the facility shall record and keep up to date the address and phone number of the resident's preferred contact. *Her Medical Information face sheet listed her primary emergency contact as her sister. *She had Saint Louis University Mental Status (SLUMS) Cognitive Evaluation Screenings on the following dates: -On 5/8/24 and 6/7/24 her scores were twenty-eight out of thirty which indicated she had no cognitive impairment. -On 7/23/24 her score was twenty-five out of thirty which indicated she had no cognitive impairment. -On 12/28/24 her score was twenty-two out of	S 800	Regional Director of Operations will review with ED resident information sheet which is part of contract signing to ensure that contacts are provided by resident before moving in. This will be completed by 2/28/25	

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thirty which indicated she had mild cognitive impairment.
*Her current care plan indicated her emergency contact was her sister and her practitioner was a physician at the VA.

Review of resident 1's progress notes from 5/26/24 through 1/15/25 revealed:
*On 8/9/24 at 8:45 p.m. she had an unwitnessed fall in her room trying to get undressed to shower. She had a scrape on her buttocks and no other injuries.
-There was no evidence her representative or physician were notified.
*On 9/3/24 at 10:27 a.m. she had returned to the facility from a leave of absence with a bruise noted on the left side of her face above her eye. She was unsure of how or when it happened.
-There was no evidence her representative or physician were notified.
*On 10/28/24 at 5:28 a.m. staff noted a bump on her forehead. The resident reported she fell around 8:00 a.m. on 10/27/24 but had not told anyone. She stated she had tripped on a cord and hit her head on the floor.
-Staff indicated they had left a message for her sister but there was no evidence her physician was notified.
*On 11/7/24 at 4:09 p.m. she was sitting in her vehicle in the parking garage with it running. The note included that staff were aware she did not have a valid driver's license, she had recently sustained a left ankle fracture and was supposed to be non-weight bearing for six to eight weeks, and her wheelchair was located in front of the vehicle. She reported to staff she was reading mail and letting her car run to keep the battery from dying. Staff escorted her back to her apartment.
-There had been no documentation of notification

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to her representative or physician.
*On 11/16/24 at 1:32 p.m. she had been found on the floor in her room and had a small bump on the back of her head. She refused to see a provider for evaluation.
-The notes had not included notification to her representative or physician.
*On 11/17/24 at 5:14 p.m. a note indicated IL resident 4 had been in the resident's room drinking beer with her. Staff reminded her about her falls.
*On 11/23/24 at 9:00 p.m. staff noted the resident appeared to be under the influence of alcohol and had a large bottle of alcohol on the counter in her room.
-There had been no documentation to support her representative or physician had been updated related to her drinking alcohol.
*On 11/29/24 at 6:38 a.m. staff noted both of the resident's hands were very swollen and bruised.
*On 11/29/24 at 1:20 p.m. the nurse assessed her hands and the resident denied falling. The resident's VA case manager was notified and planned to see the resident on 12/2/24.
-There was no documentation to support notification to her representative or physician.
*On 12/28/24 at 8:03 p.m. a late entry note of "situation between resident and IL male resident, resident had invited male resident over for dinner and movie. Male resident began making unwanted advances, resident pushed pendant. Med aide got male resident to leave room. Notified this [health services director] HSD who notified [executive director] ED. Police contacted. Report filed. State report filed."
-There was no mention of her representative or physician being notified.
*On 12/30/24 at 9:24 a.m. note of:
-"[Resident] put on pendant for assistance. Staff responded and [resident] was asking for help

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getting [IL resident 4] off of her. Staff assisted him off, with some resistance, and [IL resident 4] left room. HSD, ED, police all notified."
-"Staff will provide spot checks each shift to make sure resident is safe."
--There was no mention of her representative or physician being notified.
*On 1/6/25 at 4:42 p.m. the resident had an unwitnessed fall and her wrist appeared deformed and swollen. HSD B contacted her VA case manager and sent her to the emergency room. HSD B was notified that the resident was transferred to a different hospital and was admitted.
-There were no notes indicating her representative or primary physician had been notified.
*On 1/13/25 at 3:03 a.m. "This HSD was contacted by staff [CMA D and CMA E] am at 135 that when they went to answer pendant and found resident on floor with blood around her. [IL resident 4] was standing in the corner of room closing the blinds. Staff had [IL resident 4] return to room, they did note blood on his clothes. HSD informed staff to leave residenton [resident on] floor until police arrive. HSD contacted 911 and officers arrived right after HSD all entered resident room staff was with resident and residnet [resident] still on floor naked with old shower curtain covering her. police then took over scene. ED contacted and wasa [was] also on scene."
-There was no mention of her representative or physician being notified
*The above 1/13/25 note was the last progress note in her record.

Interview on 1/16/25 at 9:25 a.m. and again at 1:50 p.m. with HSD B and ED A regarding resident 1 revealed:
*The resident was cognitively intact and made her

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S 800	Continued From page 17 own decisions. *They confirmed her admission record and face sheet had listed her sister as her emergency contact. *After admission the resident had changed her mind and had told them she did not want her family notified related to her care. *They had not updated their records related to the resident's wishes for an emergency contact. *Typically when the resident had falls or changes they would have notified the resident's VA case manager. *They confirmed the above notes had not included documentation to support her representative or physician being notified related to her falls or changes in condition. Review of the provider's 5/13/23 Fall Management and Post Fall Investigations policy revealed: "The resident responsible party and physicians are notified of falls." A policy on notification to practitioners and resident representatives had been requested on 1/16/25 at 11:55 a.m. from ED A. The policy received was dated 11/1/14 and was titled Communication with Physician or Other Health Care Provider. That policy had not addressed notifications to practitioners related to falls and changes of condition.	S 800	Type text here	
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,	S 838		

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S 838	Continued From page 18 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, observation, and policy review, the provider failed to ensure one of one sampled resident (1) was protected and kept safe from sexual and mental abuse by an independent living (IL) resident (4) who resided on the premises. Findings include: 1. Review of the provider's South Dakota Department of Health (SD DOH) facility-reported incidents (FRI) submitted on 12/28/24 at 6:54 p.m. and 12/31/24 at 5:59 p.m. for a suspicion of resident to resident abuse by IL resident 4 to resident 1 revealed: *The event occurred on 12/27/24 at 8:00 p.m. in resident 1's room. *The brief explanation included: -Health Services Director (HSD) B was contacted after a caregiver and certified medication aide (CMA) had answered resident 1's call pendant and found the male resident on top of resident 1 in her room. -Resident 1 was asking for help. -The CMA attempted to remove the IL resident 4 away from resident 1 and he became combative and aggressive. -IL resident 4 attempted to push the CMA out of the way and out of the room but the CMA was able to get him back to his own room. -Both residents were clothed. -The CMA checked on resident 1 and notified HSD B who contacted executive director (ED) A. -HSD B and ED A arrived at the facility, spoke	S 838	Resident A discharged on 1/13/25 Resident B discharged 1/13/25 ED will be providing abuse and neglect training and resident rights for all staff. ED will audit 10% of residents to determine if they feel safe from abuse and neglect. RDO and RDHS will review abuse neglect with ED and HSD RDO will review grievances for approrpriate follow up with ED quarterly until compliance is acheived.	 2/17/25 2/28/25 2/13/25 2/28/25

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with resident 1, and called 911.
-A law enforcement report and case was filed.
-Resident 1 admitted to law enforcement that she and IL resident 4 had a close friendship.
--She had invited him over for dinner, movies, and a drink.
--During the movie things escalated and IL resident 4 would not take no for an answer so she pushed her call pendant for help.
-Law enforcement interviewed both residents.
-Resident 1 did not press charges and law enforcement recommended both residents stay away from one another.
*The investigation conclusion included:
-"No charges filed, police recommended both residents stay away from each other and staff will enforce this to best of ability. Safety checks every two hours has been placed on female assisted living resident's plan of care, she has been educated to push pendant if male independant [independent] resident knocks on door or attempts to contact with her. Staff has been educated to re-direct male resident back to his apartment if needed. If male resident does not comply then staff has been directed to contact 911 and notify [HSD B] and [ED A] immediately. Independant [independent] resident's family (Son) [name] has been notified of situation..."
*There was no mention of resident 1's representative or physician having been notified.

Review of the provider's SD DOH FRI submitted on 1/13/25 at 9:29 p.m. for a suspicion of resident to resident abuse by IL resident 4 to resident 1 revealed:
*The event occurred on 1/13/25 at 1:30 a.m. in resident 1's room.
*The brief explanation included:
-HSD B was contacted by CMAs at 1:35 a.m. that they had answered resident 1's call pendant and

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found her on the floor with blood around her.
-IL resident 4 was standing in the corner of the room closing the window blinds.
*Staff noted blood on IL resident 4's clothes and had him return to his room.
*HSD B directed the CMAs to leave resident 1 on the floor until law enforcement arrived.
*HSD B contacted 911 and law enforcement arrived to the facility right after she had.
*HSD B and law enforcement entered resident 1's room and she was still laying on the floor.
*Resident 1 was naked with an old shower curtain covering her.
*Law enforcement took over the scene.
*ED A was contacted and arrived to the facility.
*Resident 1 told law enforcement she had let IL resident 4 into her room to watch movies even though she had been told not to.
*The investigation conclusion included:
-"Emergency eviction of IL [independent living] resident. Facility worked with VA [veteran's affairs] Social worker on AL [assisted living] resident [name]. AL resident will also be evicted and with [VA] services will be placed in a skilled facility or rehab. and to help find permenent [permanent] placement."
*There was no mention of:
-Resident 1's representative or physician having been notified.
-The follow up for either resident or their current status.
-What the investigation had identified had occurred during the above event.
-If abuse had been substantiated or what type of abuse had occurred.
-Details of the event or follow up actions by the staff and facility other than the eviction of both residents.

Review of documents received from the SD DOH

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complaint department and law enforcement revealed:
*On 1/14/25, 1/15/25, and 1/16/25 additional reports and information related to the above incidents had been submitted from other agencies and providers.
*Those reports included:
-Concerns for resident 1 having been a vulnerable adult and at risk for abuse.
-On 1/13/25 resident 1 allowed IL resident 4 into her room to watch a movie and drink. Resident 1 felt pressured to drink whiskey. She felt she drank too much and when she attempted to go to bed IL resident 4 offered to help her. She ended up falling and while on the floor IL resident 4 digitally penetrated her. Resident 1 said at some point there was bleeding but she thought it was IL resident 4. Resident 1 was seen in the hospital for a sexual assault evaluation.
-The alleged perpetrator (IL resident 4) had ongoing access to resident 1 as he lived in an apartment close to her.
-Resident 1 was evaluated for a sexual assault on 1/13/25 after the facility had notified emergency services. She had an outpatient surgery planned that same date for her wrist. While at the hospital for that surgery hospital staff were told by facility staff that resident 1 was not able to return to the assisted living due to falls and she did not have anyone checking on her often enough.
-On 1/13/25 an assault between IL resident 4 and resident 1 had occurred in the facility with a similar previous event that had no criminal charges filed.
--That report had additional details and a description of the 1/13/25 event that indicated sexual abuse of resident 1 had occurred and a law enforcement case was filed.

Interview on 1/15/25 at 10:50 a.m. with HSD B

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regarding the above incidents revealed:
*Neither of the residents were in the facility at the time of the survey.
*Resident 1 remained at the hospital following her outpatient surgery on 1/13/25 while the hospital was working on a discharge plan for her.
*She would not be allowed to return to the facility due to concerns for her safety.
*IL resident 4 had left the evening of 1/13/25 around 6:30 p.m. with his son.
-He would not be allowed to return to the facility.
*Law enforcement was involved in the situation due to safety concerns for the residents.
*Surveyors requested all documentation related to those safety concerns and residents for review.

Record review of the provider's 1/13/25 SD DOH FRI report and interview with HSD B and ED A on 1/15/25 at 11:00 a.m. revealed:
*Resident 1 and IL resident 4 had been friends prior to the 1/13/25 incident.
*In December 2024 there had been another event that was reported to DOH and law enforcement that involved the same two residents.
*After the first incident in December 2024 resident 1 had been told not to let IL resident 4 into her room and staff had performed every two hour wellness checks for her.
*They stated the residents had rights and the ability to make their own choices and law enforcement had told them there was nothing more they could do when they had responded to the 12/27/24 incident.
-Resident 1 had chosen not to press charges against IL resident 4 at that time.
*For the 1/13/25 incident when HSD B was called by the staff she told them to stay with resident 1 and get IL resident 4 out of resident 1's room.
-She called 911, came to the facility right away, and notified ED A.

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*HSD B arrived to the facility at the same time as law enforcement and they went into resident 1's room.
*Resident 1 was laying on the floor and there was blood noted on her, the floor, and the walls.
-They could not identify where the blood was coming from.
-Resident 1 was interviewed by law enforcement and sent to the hospital for an evaluation by emergency services personnel.
*IL resident 4 was later evaluated by HSD B and ED A in his room.
-He had skin tears on his right and left arms and blood was noted on his clothes.
*Law enforcement had not talked with IL resident 4 while in the facility related to the 1/13/25 incident.
*IL resident 4 had short-term memory problems and had not recalled the 1/13/25 incident when they checked on him afterward.
*Resident 1 had mild cognitive impairment according to her most recent cognitive screening in December 2024.
*Resident 1 had a fall about a week prior to the 1/13/25 incident.
*From that previous fall she had broken her right wrist and had been wearing a splint/cast to that arm.
-She had already been scheduled for an outpatient surgery on 1/13/25 for her wrist so she had remained at the hospital following the 1/13/25 incident with IL resident 4 in order to have that surgery.
*Resident 1 had a history of falls they felt were related to her alcohol consumption.
*Resident 1 had a VA case manager who assisted with her health condition, consults, and other needs.
-In the past HSD B had updated the resident's case manager that they were concerned for her

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	47881	A. BUILDING: ___ B. WING ___	C 01/16/2025

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PONDEROSA LODGE SENIOR LIVING	**7400 S LOUISE AVE SIOUX FALLS, SD 57108**

(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
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safety related to alcohol use, falls, and unsafe choices.
*They again indicated residents had rights and they could not keep them from drinking alcohol in the facility.

Continued interview with HSD B and ED A regarding the background of resident 1 and IL resident 4 revealed:
*Resident 1 had admitted to the facility on 5/13/24 after a hospitalization and rehab stay.
*IL resident 4 had been living there since April 2023.
-There was no documentation or record for IL residents as they were not assisted living residents.
*Resident 1 and IL resident 4's apartments were near each other on one of the wings of the 2nd floor.
-Due to the close proximity of their apartments it was "hard to keep them apart."
*Assisted living residents and IL residents resided throughout the building and there was no designated area or unit for separation.
*Resident 1 and IL resident 4 had become friends after resident 1 had broken her ankle from a fall several months prior.
*Both residents had dogs living with them in the facility.
-After resident 1's fall and ankle injury IL resident 4 helped her to care for her dog.
*HSD B and ED A indicated there had been no concerns with the residents or their relationship prior to the 12/27/24 incident.
*After that 12/27/24 incident they had been informed IL resident 4 had been helping resident 1 with more than just caring for her dog.
-He had helped her with errands, helping her into bed, and other things.

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S 838	Continued From page 25 Continued interview and record review on 1/15/25 at 11:30 a.m. with HSD B and ED A regarding the 1/13/25 incident revealed: *When law enforcement arrived they had taken over the scene in resident 1's room including documenting the area, interviewing the resident, and assisting the emergency services personnel with preparing the resident to transport to the hospital. *After the incident ED A indicated she had notified IL resident 4's son that he needed to leave the facility due to the incident. -IL resident 4's son did not live in town and was not able to pick up him right away. -IL resident 4 remained in the facility from after the 1:30 a.m. incident until around 6:30 p.m. that evening when his son was able to pick him up. *There was no additional monitoring of IL resident 4 after either event other than the staff's two-hour safety checks that were not documented. -Because IL resident 4 was not assisted living level of care he did not have a care plan or documentation in a record. *Resident 1's current care plan had not included two-hour safety checks as indicated in the conclusion of the 12/27/24 event's FRI report. *Resident 1's care plan included: -"Safety checks per policy." -"Spot checks" three times daily at 10:00 a.m., 7:00 p.m. and 12:15 a.m. with a date of 12/27/24 and a note of "Check on resident to see that she is safe in her apartment." -"Safety: Shift Wellness Check" daily, with no time specified, and a note of "Safety check to ensure that [room number of IL resident 4] is not following or harrassing [harassing] resident. Redierct [redirect] [IL resident 4] back to apartment and notify [HSD B] or [ED A]." *The policy on safety checks was requested at that time.	S 838		

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*HSD B confirmed the care plan had not been updated according to the FRI report to ensure two hour safety checks were occurring after the 12/27/24 incident and prior to the 1/13/25 incident.
*Staff were supposed to document their safety checks in the resident's progress notes.
-Copies of those notes were requested at that time.
*Surveyors requested to speak with the caregiver staff who worked during the 12/27/24 and 1/13/25 incidents.
-They indicated CMA E who worked the overnight on 1/13/25 was no longer employed and was unavailable to interview.
-The other caregivers would be available by phone.

Interview and policy review with HSD B on 1/15/25 at 12:00 p.m. regarding the provider's safety check policy revealed:
*The wording of "safety checks per policy" automatically populated onto residents' care plans in their electronic medical record.
*There was no specific safety check policy for staff to reference.
*The corporate policy related to safety checks was titled Protective Supervision and it related to memory care units, which they did not have.

Observation and interview on 1/15/25 at 12:15 p.m. with HSD B and ED A in resident 1's apartment revealed:
*The apartment appeared disorganized with a lot of personal items.
*It had a kitchenette, dining area, living room area, two bedrooms, and two bathrooms.
*The hallway to the bedrooms had stains on the carpet and the walls between the bedroom and bathroom that appeared to be dried blood.

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*They indicated that area was where resident 1 had been found on the floor on 1/13/25 by the staff.
*There was a partially full bottle of whiskey on the kitchenette counter, a half-full glass of amber colored liquid near that, and a half-full glass of amber colored liquid on the floor in the middle bedroom near a loveseat sofa.
*They explained the apartment had been left in the condition it was from the night of the 1/13/25 incident and the glasses contained whiskey the residents had been drinking.
*They were told the residents had been watching a movie in that middle bedroom prior to resident 1 falling, being found by the staff on the floor, and resident 1 reported being touched sexually without her consent.
*There were two staff scheduled during the overnight shifts for the entire building.
-One staff was assigned to the two floors of the A and B wings and the other staff was assigned to the two floors of the C wing.
*Both staff working the overnight of 1/13/25 had responded to the incident.

Review of resident 1's care record revealed:
*She had admitted on 5/13/24.
*Her diagnoses included: neurocognitive disorder, history of seizures, alcohol dependence, history of a traumatic brain injury, anxiety, depression, and ataxic gait (uncoordinated and unsteady walking).
*She had Saint Louis University Mental Status (SLUMS) Cognitive Evaluation Screenings on the following dates:
-On 5/8/24 and 6/7/24 her scores were twenty-eight out of thirty which indicated she had no cognitive impairment.
-On 7/23/24 her score was twenty-five out of thirty which indicated she had no cognitive impairment.

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-On 12/28/24 her score was twenty-two out of thirty which indicated she had mild cognitive impairment.
*Her Fall Risk evaluations on 5/8/24 and 7/17/24 indicated she was at low risk for falls.

Review of resident 1's progress notes from 5/26/24 through 1/15/25 by the caregivers, CMAs, and licensed nurses included the following:
*On 8/9/24 at 8:45 p.m. she had an unwitnessed fall in her room trying to get undressed to shower. She had a scrape on her buttocks and no other injuries.
-The next note was not until 8/14/24 and had not supported follow up from her fall.
*On 9/3/24 at 10:27 a.m. she had returned to the facility from a leave of absence with a bruise noted on the left side of her face above her eye. She was unsure of how or when it happened.
-The next note was not until 9/26/24 which had not supported follow up to the injury.
*On 10/28/24 at 5:28 a.m. staff noted a bump on her forehead. The resident reported she fell around 8:00 a.m. on 10/27/24 but had not told anyone. She stated she had tripped on a cord and hit her head on the floor.
-The next note was on 10/30/24 at 1:46 p.m. which indicated she had been found on the floor in her bedroom doorway.
*On 11/7/24 at 4:09 p.m. she was sitting in her vehicle in the parking garage with it running. The note included that staff were aware she did not have a valid driver's license, she had recently sustained a left ankle fracture and was supposed to be non-weight bearing for six to eight weeks, and her wheelchair was located in front of the vehicle. She reported to staff she was reading mail and letting her car run to keep the battery from dying. Staff escorted her back to her apartment.

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S 838	Continued From page 29 -There had been no indication of when that left ankle fracture had occurred in the notes prior to that or assessments related to it. *On 11/16/24 at 1:32 p.m. she had been found on the floor in her room and had a small bump on the back of her head. She refused to see a provider for evaluation. -The notes had not included follow up assessment of her condition. *On 11/17/24 at 5:14 p.m. a note indicated IL resident 4 had been in the resident's room drinking beer with her. Staff reminded her about her falls. *On 11/23/24 at 9:00 p.m. staff noted the resident appeared to be under the influence of alcohol and had a large bottle of alcohol on the counter in her room. *On 11/29/24 at 6:38 a.m. staff noted both of the resident's hands were very swollen and bruised. -There was no indication of this being a concern prior or if the resident reported what had happened. *On 11/29/24 at 1:20 p.m. the nurse assessed her hands and the resident denied falling. The resident's VA case manager was notified and planned to see the resident on 12/2/24. -The next note was not until 12/22/24 and it had no indication of her health status or what had occurred with her hands. -That note was that she was going out on a leave and forgot to take her medications with her. *On 12/28/24 at 1:00 a.m. and 3:08 a.m. notes of "Safety check, asleep, door locked." *On 12/28/24 at 8:03 p.m. a late entry note of "situation between resident and IL male resident, resident had invited male resident over for dinner and movie. Male resident began making unwanted advances, resident pushed pendant. Med aide got male resident to leave room. Notified this HSD who notified ED. Police	S 838		

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contacted. Report filed. State report filed."
-There was no mention of her representative or physician being notified.
*On 12/30/24 at 9:24 a.m. note of:
-"[Resident] put on pendant for assistance. Staff responded and [resident] was asking for help getting [IL resident 4] off of her. Staff assisted him off, with some resistance, and [IL resident 4] left room. HSD, ED, police all notified."
-"Staff will provide spot checks each shift to make sure resident is safe."
*On 1/1/25 at 1:49 a.m. and 5:44 a.m. notes of "Safety check, door locked, asleep."
*On 1/2/25 at 12:08 a.m. "Safety check, resident says, [IL resident 4] let himself into her room, when she had just got back from checking her clothes. He wouldn't leave so she asked him to walk the dog and pressed her button, waited for Resident to get her dog back, walked with her to the laundry room, to check how long her clothes have, got her clothes, and checked her room to make sure it was just her, locked her door."
*On 1/2/25 at 5:49 p.m. "Resident pendant alerted staff. [IL resident 4] knocking on her door. [IL resident 4] re-dierected [re-directed] back to his apartment. This HSD notified and sdpoke [spoke] with [IL resident 4] and reminded him he may not have any contact with resident [1]."
*On 1/3/25 at 5:54 a.m. "Checks at 2 and 4 resident woke up to me knocking at door and unlocking to see if she was alright. Resident was alone in room and said no one had bothered her all night."
*On 1/5/25 at 1:51 a.m., 3:35 a.m., and 11:40 p.m. "Safety check, door locked, asleep."
*On 1/6/25 at 4:42 p.m. the resident had an unwitnessed fall and her wrist appeared deformed and swollen. HSD B contacted her VA case manager and sent her to the emergency room. HSD B was notified that the resident was

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transferred to a different hospital and admitted.
-There were no notes indicating the resident had returned to the facility or follow up to her wrist injury.
*On 1/8/25 at 6:30 a.m. "Resident had put on pendant and stated [IL resident 4] was knocking and ringing her door bell and that she did not open the door. Writer ensured that the door was locked when leaving the room."
*On 1/10/25 at 12:51 a.m., 3:51 a.m. and 10:07 p.m. and 1/11/25 at 1:42 a.m. notes all stated "Safety check, door locked, asleep."
*On 1/13/25 at 3:03 a.m. "This HSD was contacted by staff [CMA D and CMA E] am at 135 that when they went to answer pendant and found resident on floor with blood around her. [IL resident 4] was standing in the corner of room closing the blinds. Staff had [IL resident 4] return to room, they did note blood on his clothes. HSD informed staff to leave residenton [resident on] floor until police arrive. HSD contacted 911 and officers arrived right after HSD all entered resident room staff was with resident and residnet [resident] still on floor naked with old shower curtain covering her. police then took over scene. ED contacted and wasa [was] also on scene."
-There was no mention of her representative or physician being notified, her report of being touched sexually, or additional details that supported what had occurred during that incident.
*The above 1/13/25 note was the last progress note in her record.

Phone interview on 1/15/25 at 1:00 p.m. with CMA D regarding the above residents revealed:
*She had worked at the facility for a little over a month on the overnight (10:00 p.m. through 6:30 a.m.) shift.
*She had been assigned to the C wing during the overnight shift on 1/13/25.

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S 838	Continued From page 32 *When resident 1's call pendant had alerted staff for help at 1:30 a.m. the other staff member assigned to the A and B wings, CMA E, had responded to it. *After CMA E got to resident 1's room she called CMA D for help. *When she walked into resident 1's apartment she saw the resident laying on the floor in the hallway naked with a small cover on her and blood on the floor and the wall. *She immediately called HSD B who indicated she would come to the building and would notify law enforcement and an ambulance. *She and CMA E stayed in the room with resident 1 to make sure she was safe until help arrived and got IL resident 4 to leave resident 1's room. *After HSD B and law enforcement arrived they answered some questions and then she went back to her other work duties. *She had been aware a previous incident had occurred between resident 1 and IL resident 4 prior to the 1/13/25 incident. -She thought IL resident 4 had made "unwanted advances" to resident 1 and the staff were supposed to increase safety checks for resident 1. *They were documenting safety checks for resident 1 around 12:00 a.m. everyday. -She was unsure how often those safety checks should have been performed and documented. *She was not aware of any additional monitoring or interventions for IL resident 4. *She could not recall having additional education or training related to resident 1 and IL resident 4 or that previous incident. *She was aware of IL resident 4 trying to get into resident 1's room another time when she responded to resident 1's call pendant and she documented that in her notes.	S 838		

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Interview on 1/15/25 at 3:45 p.m. with CMAs F, G, and H regarding staff training and education revealed:
*CMA G was in her first week of employment and was working on the C unit.
*CMA H was on her second day of employment and was training with CMA F.
*CMA F had worked there for over a year.
*All indicated they would have completed any online training they were assigned.
-That included training on abuse and neglect and resident rights.
*They had been aware of recent incidents between resident 1 and IL resident 4.
*Resident 1 was supposed to push her call pendant if she needed staff's help.
*If there were any concerns with any residents they would have reported those to HSD B.

Continued interview on 1/15/25 at 4:10 p.m. with CMA F revealed:
*She primarily worked the twelve-hour daytime shifts (6:00 a.m. through 6:30 p.m.).
*She was familiar with residents throughout the building.
*She felt IL resident 4 had behaviors towards staff and other residents in the past.
*Some staff said IL resident 4 had made sexual comments or would get close to them, but he had not done that to her.
*One time she had to redirect IL resident 4 away from a cognitively impaired resident in the dining room when he tried to kiss that female resident's cheek.
*She had also heard of another female resident who reported IL resident 4 had kissed her without her consent.
*Resident 1 and IL resident 4 were friends and he frequently helped resident 1 with her dog.
*IL resident 4 referred to resident 1 as his

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girlfriend at times.
*IL resident 4 had been used to being around resident 1 quite a bit and he did not understand he should not be in her room or around her anymore after the December 2024 incident.
*She felt IL resident 4 had issues with his memory and he could not remember he was not supposed to be around resident 1.
*She did not recall IL resident 4 trying to go into any other residents' rooms other than resident 1.
*At times resident 1 had been noted to be drinking alcohol in her room and both residents had been drinking together in the past.
*She was not aware of any falls for resident 1.
*Resident 1 had kept her door locked most of the time, but she did allow IL resident 4 into her room at times too.
*She was not sure if resident 1 was scared of IL resident 4 but felt resident 1 seemed to be annoyed with him and "tried to avoid him."

Interview on 1/15/25 at 4:40 p.m. with resident 1 revealed she:
*Had a "big" fall at her home in another town sometime last year in January 2024 which resulted in a hospital stay.
*Had lived at the facility since May 2024.
*Had experienced falls during her stay at the facility.
*Had a friendly relationship with IL resident 4 as they both had pet dogs and enjoyed watching movies.
*Was not sure when "the problems started" with IL resident 4, but he kept saying to her "I love you, I love you" and she would push him away.
*Stated after the 12/27/24 incident with IL resident 4 she started locking her apartment door as she was scared of him.
*Stated IL resident 4 kept pursuing her and knocked on her apartment door "at least once a

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day."
*Would push her call pendant for staff to assist sometimes when he was knocking or wanted to come into her room.
-Sometimes he was no longer there by the time the staff answered her pendant.
*Had been told to quit pushing her pendant and felt some staff thought she was imagining things since IL resident 4 would no longer be there by the time the staff arrived.
*Did not remember much of the incident from 1/13/25 but remembered watching a movie and having drinks with him.
*Stated "I shouldn't have let him in. I don't know what he did, but it wasn't right."
*Felt the blood all over the place in her room that night was from IL resident 4, not her.
*Had been at the hospital since the incident on 1/13/25.
*Had been released from the hospital that afternoon, 1/15/25, and had stopped by to get some items from her apartment before going to her home in another town where she planned to live as she could not return to her assisted living apartment.
*Stated a "VA [Veteran's Administration] nurse was coming tomorrow" to her home in a nearby town to set up services.
*Was tearful throughout the interview and expressed how sorry she was to the staff and stated "I know I'm a burden on them."

Phone interview on 1/15/25 at 5:06 p.m. with CMA C revealed:
*She had worked at the facility for a few years and primarily worked overnight shifts.
*She was familiar with the whole building and residents.
*She worked the overnight shift on 12/27/24 when the first incident had occurred that evening

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PONDEROSA LODGE SENIOR LIVING	7400 S LOUISE AVE SIOUX FALLS, SD 57108

(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 36 between resident 1 and IL resident 4. *That evening resident 1's pendant alerted and her coworker responded to it. *Her coworker reported she did not see resident 1 in her room so CMA C went to check on resident 1 herself. *When she went to check on resident 1 she saw the resident's dog so she knew the resident was in her apartment. *She went down the hallway and noted the middle bedroom was dark and resident 1 was on the sofa with IL resident 4 leaned over her. *She asked if resident 1 was okay and heard her say "No" and then quietly say "Help." -Resident 1 was not crying, but her face looked uncomfortable. *IL resident 4 had been touching resident 1 inappropriately. -CMA C asked him to stop and he did not stop. *CMA C had to physically move him away from resident 1 and he got more aggressive the more she tried to separate them. *When he became aggressive, he had grabbed the staff's arms and told her she needed to leave. *She did eventually get IL resident 4 to go back to his apartment and then she went back to ask resident 1 if she was okay or if she was hurt. *Resident 1 did not want anyone called so she and her coworker assisted the resident to her bed. *While they were helping resident 1, IL resident 4 returned to resident's 1's room and staff redirected him back to his room. *They told resident 1 they would call HSD B and resident 1 said she did not want to make a report. *The staff notified HSD B and ED A who came to the facility and spoke with resident 1. *She knew they also notified law enforcement who spoke with both residents. -Resident 1 did not want IL resident 4 arrested,	S 838		

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	47881	A. BUILDING: ______ B. WING ______	C 01/16/2025

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S 838	Continued From page 37	S 838		

she just wanted him to stay away from her.
*After law enforcement arrived she went back to her normal work duties.
*IL resident 4 tried to return to resident 1's room more than once, even when law enforcement was there.
*After law enforcement left that evening they made sure resident 1's room door was locked and staff checked on her every two hours.
*She documented those checks in the resident's progress notes, but was not sure if they were documented for all the times they were done.
*Staff was directed to do checks to make sure resident 1's door was locked and to redirect IL resident 4 away from resident 1 if they noticed him going near her.
*After the incident CMA C had worked an evening shift when resident 1 went to the laundry room and IL resident 4 had followed her.
-Resident 1 used her pendant, CMA C responded and then escorted resident 1 to the laundry and back to her room.
*Resident 1 used her pendant several times when IL resident 4 was knocking or wanted into her room.
-She estimated that occurred an average of three times every night and felt it had increased after the 12/27/24 incident.
*She felt IL resident 4 watched for when resident 1 came or went from her room with her dog.
*Resident 1 seemed embarrassed, humiliated that people would know, and scared of IL resident 4.
-She reported resident 1's voice being shaky and told staff "I feel watched."
*She could not recall any recent or specific training related to these residents or the incidents.
*She had done the required online training for abuse and residents' rights.

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S 838	Continued From page 38 *She felt what occurred between resident 1 and IL resident 4 was abuse. *She asked what more they could have done because after the 12/27/24 staff had been told to make sure resident 1's door was locked and to redirect IL resident 4 away from resident 1, but she knew another incident had occurred on 1/13/25. *She was not aware of IL resident 4 having behaviors towards other residents, but had heard from other staff they were uncomfortable with him touching them inappropriately. *She felt IL resident 4 had memory issues and he would say "he lives here" or "this is my house" when he was referring to resident 1's room. *When she worked after the 12/27/24 incident she monitored resident 1's room door for being lockedand checked on her more often, but she had not documented each time that was done. Review of the provider's staff training documentation for December 2024 and January 2025 revealed: *There had been an all-staff meeting on 1/8/25. *There was no documentation to support staff training had occurred for these individualized residents' needs and the plan to ensure resident 1's safety. Review of resident 1's Resident Event Report that recorded each time the resident used her call pendant from 12/1/24 through 1/13/25 revealed: *From 12/1/24 through 12/26/24 she utilized her call pendant a total of ten times. *On 12/27/24 she had utilized her call pendant at 7:48 p.m. which correlated with the evening of the first incident between her and IL resident 4. *From 12/27/24 through 1/13/25 she utilized her call pendant a total of twenty-two times. -That was over twice as often in a shorter	S 838		

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S 838	Continued From page 39 timeframe and correlated with the staff and resident interviews. *On 1/13/25 she had utilized her call pendant at 1:30 a.m. which correlated with the incident on that day and time. Interview on 1/16/25 at 9:25 a.m. and again at 1:50 p.m. with HSD B and ED A revealed: *They confirmed the incidents on 12/27/24 and 1/13/25 between resident 1 and IL resident 4 were concerning. *They had reported both incidents to law enforcement and to the SD DOH as they were related to abuse. *It had been difficult for staff to keep the residents apart from one another as they had been friends prior, had apartments close together, were both independently mobile, and had chosen to drink and socialize together. *They were aware of the facility's role to ensure the health and safety of all residents. *Both residents were no longer residing on the premises due to safety concerns. Review of the provider's revised 3/10/23 Resident Abuse and Neglect policy revealed: *"...All allegations of abuse or neglect will be treated as serious and will be investigated, documented, and reported per the standards set forth in this policy and procedure, or per State or Federal regulations..." *Definition: "Abuse: the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult..." -"...Abuse includes physical abuse, sexual abuse, mental abuse, and exploitation of a vulnerable adult..." -"Sexual Abuse: any form of non-consensual contact, including but not limited to unwanted or	S 838		

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S 838	Continued From page 40 inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment." -"Mental Abuse: any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing." *For Reporting Witnessed or Suspected Abuse or Neglect: -"A. The safety of the Resident will be maintained. The resident will be kept separated from the alleged abuser throughout the course of the investigation." -"D. The alleged abuse incident will also be reported to the Resident's responsible party, if applicable." *For Investigation of Alleged Abuse or Neglect: -"A. Resident safety will be ensured, and medical treatment and supportive services will be provided as necessary. The Resident's primary care physician will be notified if indicated. *For Other Resident as Alleged Abuser: -"A. If the alleged abuser is another Resident, a thorough evaluation will be conducted to determine possible causes of their behavior, including physical, behavioral, pain and/or depression. If the behavior persists and is not able to be managed by Community staff, emergency personnel will be summoned." -The alleged abusing resident's physician would be notified to assist in evaluation and need for treatment and their family would be notified with changes and follow up. *For Visitor or Family Member as Alleged Abuser: -"B. If the alleged abuser was a non-family visitor, the responsible party, if one exists, will be notified of the alleged incident."	S 838		

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S 838	Continued From page 41 -"C. Every effort should be made to keep the alleged abuser and the Resident separated pending the results of the investigation." -"D. If the local police were contacted, their direction will be followed concerning appropriate action regarding the alleged abuser." *Conclusion of Analysis of Investigation included: -"E. Establish Resident Abuse Investigation File which includes: --a. a copy of the incident report. --b. all Alleged Resident Abuse Interview documentation. --c. a copy of any employee counseling, retraining or disciplinary action. --d. record of any discussions with regulatory agencies or police." -"G. Arrange for re-in-servicing of all staff about abuse prohibition and prevention if deemed appropriate." *Staff In-service included: -"A. Following an incident of Resident abuse, all staff will receive mandatory in-service training regarding abuse and neglect policies and procedures." -"B. Training records for such in-services will be maintained by the Executive Director."	S 838		
S 866	44:70:09:14(1-3) Admission, Readmission, Transfer and Discharg The policies and procedures must include the following provisions: (1) The resident may not be transferred or discharged unless the resident's needs and safety cannot be met by the facility, the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, the safety or health of persons in the	S 866		

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S 866	Continued From page 42 facility is endangered by the resident, the resident has failed to pay for allowable billed services as agreed to, or the facility ceases to operate. The facility shall conduct an evaluation or assessment of each resident to determine if the facility is able to meet the needs of the resident. The determination must be discussed with the resident or the resident's designated representative and documented in accordance with §§ 44:70:01:05 and 44:70:05:03. If the facility is not able to meet the needs of the resident, discharge planning in accordance with § 44:70:04:16 must be coordinated with the facility to which the resident is to be transferred or discharged, the resident, and family member or designated representative to an appropriate level of care to meet the resident's individualized needs; (2) The facility shall notify the resident or designated representative and state ombudsman in writing at least thirty days before the transfer or discharge of the resident. If the resident's health requires immediate transfer or discharge, the thirty days notice is not required. The written notice must specify the reason, effective date, and the location to which the resident will be transferred or discharged; and (3) The facility shall provide to the resident or designated representative a description of how the resident may appeal a decision by the facility to transfer or discharge the resident including the right to a fair hearing. This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), record review, and interview, and policy review, the	S 866	Regional Director of Health Services and regional Director of Operations will educate the ED and HSD on the transfer and discharge requirements per the regulations and the policy. Residents will be evaluated every 6 months or with change of of condition, and any resident that is out of our scope of practice, either by policy or regulation,will be reassessed by HSD or designee and reviewed with regional team for appropriateness. Once the determination is made that the resident is no longer appropriate for AL, a 30 day notice will be issued to resident and appropriate parties in writing. Appropriate Placement will be discussed. Ed or designee will review discharges weekly for two months and then monthly until compliance is acheived to ensure that the proper notice was given as delineated above.	2/28/25

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S 866	Continued From page 43 provider failed to notify the resident and state ombudsman in writing at least thirty days before the involuntary discharge of one of one resident (1) which included the reason, effective date, and the location to which the resident would be discharged to and failed to provide the resident a description of how the resident may appeal a decision by the facility to discharge the resident including the right to a fair hearing. Findings include. 1. Review of the provider's 12/31/24 SD DOH FRI revealed: *On 12/27/24 at 8:00 p.m. resident 1 pushed her call pendant for assistance. *A staff member responded to resident 1's second floor apartment to find independent living (IL) resident 4 on top of resident 1 in her room. *Resident 1 was asking for help. *The staff member "attempted to remove male resident [4] from on top of female resident [1] and [IL resident 4] became combative and aggressive." *"Both resident [1 and IL resident 4] were clothed." *The staff member "was finally able to get male resident [4] back to [his] own apartment, check on female resident [1] and contact this HSD [health services director B] who contacted executive director [ED A]. *Both HSD B and ED A arrived at the facility and spoke with resident 1 and contacted law enforcement. *Resident 1 did acknowledge to law enforcement officer that she and IL resident 4 had a close friendship. *Resident 1 "had invited him [IL resident 4] over for dinner, movies and a drink. *"During the movie things escalated, [and] male resident [4] would not take no for an	S 866		

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answer, and she then pushed her pendant for help."
*Law enforcement officer interviewed both residents and resident 1 had not pressed charges.
*Law enforcement officer "recommended they both stay away from one another. Officer made this recommendation clear to each resident."

2. Review of a Sioux Falls hospital provider's 1/13/25 at 2:00 p.m. SD DOH FRI revealed:
*"After the ED [Emergency Department] visit patient [resident 1] had outpatient surgery scheduled."
*"We [hospital provider] are now being told that [provider's name] facility will not accept patient back at this point in time."

3. Review of the provider's 1/13/25 at 9:29 p.m. SD DOH FRI revealed:
*On 1/13/25 at 1:35 a.m. HSD B was contacted by CMA D and CMA E after they had answered resident 1's call pendant and found resident 1 on the floor with IL resident 4 also in the room.
*The "Staff had [IL resident 4] return to room [his apartment].
*HSD B contacted law enforcement and ED A.
*Resident 1 stated to law enforcement officers that she had let male IL resident 4 into her apartment to "watch movies even though she had been told not to."
*"Emergency eviction of IL [Independent Living] resident [4]... AL [Assisted Living] resident [1] will also be evicted..."

4. Interview on 1/15/25 at 10:42 a.m. with ED A revealed resident 1 had been "discharged on 1/13/25 at 2:00 a.m. to [hospital provider name] and will not be returning.

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5. Interview on 1/15/25 at 10:56 a.m. with HSD B regarding resident 1 revealed:
*Resident 1 had a SLUMS (Saint Louis University Mental Status) exam score of 22 which indicated mild cognitive impairment.
*She had a well-known friendship with IL resident 4.
*The 12/27/24 incident between her and IL resident 4 was the first reported incident between them.
*On 1/13/25 after the incident occurred at 1:30 a.m.:
-When staff assisted her to stand, she was unbalanced due to "inebriation."
-Resident 1 had stated:
--She was not injured.
--She did not want to press charges on IL resident 4.
*Resident 1 had experienced falls related to her use of alcohol.
-Her fall on 1/6/25 at 1:10 p.m. had resulted in a fractured right wrist.
-She was scheduled for surgery on Monday, 1/13/25.
-The emergency room staff on 1/13/25 had "approved her to have [that] surgery for the fractured wrist."
*She would not be returning to the facility "due to safety" which included her "falls and alcohol consumption."
*HSD B stated the provider "can't keep her safe due to her drinking alcohol."

6. Interview on 1/15/25 at 4:40 p.m. with resident 1 revealed she:
*Had a "big" fall at her home in another town sometime last year in January 2024 which resulted in a hospital stay.
*Had lived at the facility since May 2024.
*Had experienced falls during her stay at the

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S 866	Continued From page 46 facility. *Had a friendly relationship with IL resident 4 as they both had pet dogs and enjoyed watching movies. *Was not sure when "the problems started" with IL resident 4, but he kept saying to her "I love you, I love you" and she would push him away. *Stated after the 12/27/24 incident with IL resident 4 she started locking her apartment door as she was scared of him. *Stated IL resident 4 kept pursuing her and knocked on her apartment door "at least once a day." *Had been at the hospital since the incident on 1/13/25. *Had been released from the hospital that afternoon, 1/15/25, and had stopped by to get some items from her apartment before going to her home in another town where she planned to live as she could not return to her assisted living apartment. *Stated a "VA [Veteran's Administration] nurse was coming tomorrow" to her home in a nearby town to set up services. *Was tearful throughout the interview and expressed how sorry she was to the staff and stated, "I know I'm a burden on them." Interview on 1/16/25 with Long Term Care (LTC) Regional Ombudsman, ED A, and HSD B regarding resident 1's "emergency eviction" revealed: *HSD B stated she was not aware of the history of her drinking alcohol prior to her admission. *ED A stated there were "red flags with all these events [referring to her alcohol-related falls], it was an accumulative thing." *Both ED A and HSD B stated they had discussed her drinking with the VA nurse and social worker as they wanted to keep her safe, but also respect	S 866		

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her rights.
*LTC Regional Ombudsman stated the provider needed:
-To provide a 30-day notice for discharge.
-To assist with discharge planning.
-To provide information on how to appeal the discharge decision and request a fair hearing.

Review of the provider's revised 3/10/23 Move-Out/Transfer Process revealed:
*"1. Each community adheres to state-specific laws, regulations, and guidelines (including timeframes) regarding continued residency criteria."
*Move-Out Process included:
-"2. Regardless of the reason for move-out or transfer/discharge, the community assists the resident and or responsible party in the placement process to ensure a safe and appropriate discharge or transfer occurs."
-"3. The resident and or resident's responsible legal representative is provided written move-out notification and or transfer notification according to state-specific timeframes."

Review of the provider's October 2014 Accepting and Retaining Residents policy revealed "8. When a Resident develops a condition requiring discharge, 30 days notification will be given, unless the health or safety of the Resident or others in the Community are at risk, or the resident requires urgent medical intervention requiring immediate transfer or discharge."