STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10692	A. BUILDING: _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEY CITY ASSISTED LIVING, LLC	1542 DAVENPORT STREET STURGIS, SD 57785

(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 from 7/18/23 through 7/19/23. Areas surveyed included medication administration and resident care following a fall with injury. Key City Assisted Living, LLC was found not in compliance with the following requirements: S415 and S701.	S 000		
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 met as evidenced by: Based on record review, interview, policy review, and job description review, the provider failed to ensure the licensed nurse had completed and documented her own nursing assessment in one of one resident care record (1) following a fall that had required 30 staples to the resident's head wound. The resident required transfer to the emergency room (ER) for treatment of her head wound. Findings include: 1. Review of the 6/21/23 South Dakota	S 415		

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S 415	Continued From page 1 Department of Health complaint intake information regarding resident 1 revealed patient care assistant (PCA) A: *On 6/17/23 at 7:45 a.m. she found the resident on the floor in her room in a pool of blood however, she did not indicate where the blood was coming from. *"Called 911 as [UAP F's name] was not around to call." *"The protocol following a fall is to notify the nurse [registered nurse C]." *After the resident "returned from the hospital the nurse wanted to evaluate her." *When she returned to the facility it had required two people to assist the resident out from the car. Interview and record review on 7/18/23 at 1:45 p.m. with registered nurse (RN) C (by telephone), administrator D, and former administrator E, who had the title of administrator at the time of the above incident regarding resident 1's 6/17/23 fall with injury and the follow-up from that revealed: *The RN had been notified by phone of the resident's fall and that 911 had been notified by PCA A on 6/17/23. *Former administrator E went to the emergency room with resident and the resident's daughter. -The physician informed former administrator E the resident was fine to return to the assisted living as the X-rays and other tests had been normal. -The physician had directed former administrator E to observe and monitor the resident for any changes or for an infection at the location of the staples. --Former administrator E at this time indicated the resident had required 30 staples to her head laceration. -The resident's vital signs were to have been taken to monitor for any changes.	S 415	S415 Unable to correct past non-compliance A nurse has been designated for this facility. Administrator educated nurse and all staff on emergency response procedures and proper documentation procedures for the same. Administrator educated the nurse that assessments should be conducted visually and the nurse will visually look at all residents on a weekly basis and chart accordingly or sooner in an emergency and or change of condition. Administrator or designee will monitor and audit the assessments, procedures and documentation pertaining to all emergencies and visual assessments are done randomly x 2 residents weekly then monthly for 4 months and will present audit results to the QA committee for 2 quarters.	09/02/2023

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S 415	Continued From page 2 -The physician had visited with the former administrator E directly and provided the above instructions verbally. --Former administrator E was unaware of any discharge ER instructions or where they may be located. --There was no discharge instructions in the care record following the emergency room visit. Continued phone interview and record review with RN C regarding resident 1's fall with injury and follow-up revealed her documentation on 6/16/23 at 10:40 a.m. and again at 3:40 p.m. was information obtained from the PCAs observations. She had not been working in the facility that day. Her 6/16/23 documentation included: *"At approximately 8:21 [a.m.] on 6/16/2023 I was notified from [staff members name] (PCA A) that resident was found on the floor beside her bed near the closet. Resident was found on the floor. [PCA A's name] called 911 as soon as she found her at 7:48 AM. Within less than a minute, a Sheriff was there. Shortly followed by the ambulance with 2 EMTS. Paramedics arrived and took control of treatment. Vitals signs and neuro checks were unable to be assessed due to fast response of EMTS. Resident was taken to [hospital name] Emergency Room via [by] ambulance. Family was notified per [former administrator's name]." *On 6/16/2023 at 3:40 p.m. "Resident returned back to facility in personal car accompanied by her daughter. Resident is alert to person, place, and situation. Assist x2 to get out of care, W/C [wheelchair] to transfer to her room. Stitches and glue on the corners.Incision to head is dry and intact. Resident does rate her pain at a 9 (scale of 1 to 10 with 10 being the worst pain) to her head. CT scan shoes [shows] no bleed to her head. CT	S 415		

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S 415	Continued From page 3	S 415		

to cervical spine shoes [shows] no injury. Orders for tylenol 500mg [milligrams] x2 tabs [tablets] increased to scheduled x3 daily for pain. Eliquis to hold tonight and restart tomorrow. Stitches, to be removed in 10 days. If any HA [headache]/Vomiting or mental change return to ER [emergency room]."
*She had not visually observed the resident at either time and took the opinion of the PCA who were not qualified to assess a resident like a licensed nurse would observe or should have done.
-She clarified from the above information she had received by telephone from the PCA and that was what she had documented in the resident's care record.

Phone interview with licensed practical nurse (LPN) B on 7/19/23 at 12:00 noon revealed:
*She had been the current licensed nurse at the facility since the middle of April 2023.
*She was working two days in the facility and two days a week at a sister facility.
*She had not been to this facility for the last two weeks; the last time was on a Friday and she could not remember the exact date.
*RN C had been "taking responsibility since she was considered the regional nurse for the three facilities."
*"When [resident's name] had fallen, she had been out of town and RN C was on call for the facility."
*"She had not been informed about the resident's fall at the time."
*When she visited the facility twice a week after resident 1's incident she would monitor the "incision" to make sure there was no infection and that the wound had not opened.
*"The PCAs were responsible to monitor the incision."

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S 415	Continued From page 4 *She confirmed she had not document her observations of the wound during her twice-weekly visits. -She was aware if something was not documented, it was not done. *She only documented the status of the head wound when she removed the staples on 6/29/23. Review of the provider's January 2023 Nurse Reviews policy revealed "A community Registered Nurse will review and document each resident's care, condition, and medication issues on a weekly basis." Review of the 2023 LPN - Senior Care Job Description and the 2023 RN Senior Care Job Description both revealed the major duties included: *Monitor and reassess the resident as per policy. *Interventions to address any areas of vulnerability and individualized medication management or treatment whenever the resident had a fall. *Address other incidents when there was a significant change in the resident's condition *Be available for on-call medical questions and or emergencies via phone. On-call might require the LPN to come to the facility to handle a medical emergency or staff issues. Refer to S701.	S 415		
S 701	44:70:08:01 Record service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician	S 701		

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S 701	Continued From page 5 assistant's, or nurse practitioner 's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident's physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. 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 thorough documentation occurred in one of one resident's care record (1) for the following: *What occurred after the resident had fallen until the resident was transferred to the emergency room. *The status of the resident upon the her return from the emergency room the the facility. *Discharge instructions from the emergency room physician on how to care for the resident who had received 30 staples to her head wound that had occurred after a fall. *Unlicensed staff observations or changes in the resident's status or mobility, any pain associated with her head injury, and observations of the head wound staples following the incident. Findings include: 1. Review of the 6/21/23 South Dakota Department of Health complaint intake information regarding resident 1 revealed patient care assistant (PCA) A: *Found resident 1 on the floor in her room in a pool of blood on 6/17/23.	S 701	S701 Unable to correct past non-compliance A nurse has been designated for this facility. Administrator educated nurse and all staff on emergency response procedures and proper documentation procedures for the same and proper documentation by the unlicensed personnel and reviewed by the nurse. Administrator educated the nurse that assessments should be conducted visually and the nurse will visually look at all residents on a weekly basis and chart accordingly or sooner in an emergency and or change of condition. Administrator or designee will monitor and audit the assessments, procedures and documentation pertaining to all emergencies and visual assessments are done randomly x 2 residents weekly then monthly for 4 months and will present audit results to the QA committee for 2 quarters.	09/02/2023

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S 701	Continued From page 6 *Had called 911 for emergency medical technicians (EMT) to transfer resident 1 to the emergency room (ER). *Upon resident 1's return the nurse was to have been notified to evaluate the resident. *When the resident returned to the facility it had required two people to assist her out from the car. *"They had just completed training on the protocol." Interview and record review on 7/18/23 at 1:45 p.m. with registered nurse (RN) C (by telephone), administrator D, and former administrator E, who had the title of administrator at the time of the above incident regarding resident 1's 6/17/23 fall with injury and the follow-up from that revealed: *The RN had been notified by phone of the resident's fall and that 911 had been notified by PCA A on 6/17/23. *Former administrator E went to the emergency room with resident and the resident's daughter. -The physician informed former administrator E the resident was fine to return to the assisted living as the X-rays and other tests had been normal. -The physician had directed former administrator E to observe and monitor the resident for any changes or for an infection at the location of the staples. --Former administrator E at this time indicated the resident had required 30 staples to her head laceration. -The resident's vital signs were to have been taken to monitor for any changes. -The physician had visited with the former administrator E directly and provided the above instructions verbally. --Former administrator E was unaware of any discharge ER instructions or where they may be located.	S 701		

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S 701	Continued From page 7 --There was no discharge instructions in the care record following the emergency room visit. *PCA A had difficulty getting the resident out of the car as it had required two individuals assisting the resident. *PCA A informed the family the resident could not stay at the facility due to she a two-person assist and she would need to go somewhere else for cares. *Once PCA A was able to get the resident into the facility and to her room, she then called 911 again to have them come and take the resident back to the hospital because of the assistance for mobility.. -EMTs arrived and assessed the resident by taking vital signs, assisting the resident to stand, doing a pain assessment, and completed a cognitive assessment. --The EMTs could not find any medical condition to justify a transport back to the emergency room, so they left and the resident remained at the facility. *Former administrator E indicated it would have been difficult for someone who had fallen, required 30 staples to their head, and possibly might have had pain in her head or other places to have easily gotten out of a car with one assist. -In the past resident 1 had no difficulty getting out of a vehicle that was higher such as a SUV. *RN C and administrator D confirmed PCA A had overstepped her boundaries as she was not qualified to inform the family the resident had required a transfer to a higher level of care or to re-call 911 to have the resident taken back to the emergency room. *RN C and administrator D revealed that in the resident's care record there was no documentation by any of the unlicensed staff about the following: -What occurred from the time of the staff finding	S 701		

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S 701	Continued From page 8 the resident on the floor in a pool of blood until she returned to the facility from the emergency room. -The resident's condition or status at any time regarding the resident's mobility, an evaluation of pain, or the need for a pain medication, cognitive level, or any vital signs after she had returned to the facility following the 30 staples placed for the head laceration. -The reason why 911 had been notified to return to the facility. They confirmed the only documented vital signs for the resident were on 6/7/23 prior to the fall and a pain level had only been documented on 6/30/23 and that was 14 days after the resident's fall. Interview and record review on 7/19/23 at 3:46 p.m. with administrator D revealed: *There was no fall policy in the policy and procedure manual. *Training had been provided RN C and administrator D to all staff on 6/15/23 on how to prevent falls. *The training also addressed what to do after a resident falls. This training included: -"Check for any sign of injury. Ask if they are having any pain in any particular area. -Call the nurse for instructions, Make the resident comfortable with a pillow blanket -Take the vital signs -If the resident is showing signs of injury call 911, per nurse's instructions." --There was no documentation of the above instructions at the time of the fall or upon the resident's return to the facility from the emergency room. --That training occurred the day prior to resident 1's fall.	S 701		

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S 701	Continued From page 9 Interview and record review on 7/19/23 at 4:10 p.m. with unlicensed assistive personnel F revealed: *There was a daily form to document resident vital signs. *If the resident needed to have their vital signs monitored they would have been written on that form. *Vital signs could have been documented on a sheet of paper after a resident had fallen, but it was unknown where that information was or why the vital signs had not been documented in the resident's care record. Phone interview with licensed practical nurse B on 7/19/23 at 12:00 noon regarding resident 1's fall where she required 30 staples revealed: *She has been the licensed nurse at the facility since the middle of April 2023. *She was to work two days in the facility and two days a week at a sister facility. *She had not been to this facility for the last two weeks; the last time was on a Friday and she could not remember the exact date. *RN C had been "taking responsibility since she was considered the regional nurse for the three facilities." *"When [resident's name] had fallen, she had been out of town and RN C was on call for the facility." *"She had not been informed about the resident's fall at the time." *When she visited the facility twice a week after resident 1's incident she would monitor the "incision" to make sure there was no infection and that the wound had not opened. *"The PCAs were responsible to monitor the incision." *She confirmed she had not document her observations of the wound during her	S 701		

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S 701	Continued From page 10 twice-weekly visits. -She was aware if something was not documented, it was not done. *She only documented the status of the head wound when she removed the staples on 6/29/23. Review of the provider's January 2023 Resident's Records/Charts policy revealed: *"Records/charts are to be maintained for each resident." *"3. Physician orders: -a. Physical exam form at admission. -b. Other exam forms, doctor's orders, and written prescriptions filed in date order." *"5. Staff notes: -a. Vital Sign Sheets. -b. Care Summary Notes." *The policy had not addressed: -Falls and the documentation that should have occurred related to them. -Who was responsible to complete documentation in the resident records.	S 701		

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{S 000}	Compliance Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 9/26/23 for deficiencies cited on 7/19/23. All deficiencies have been corrected, and no new noncompliance was found. Key City Assisted Living, LLC is in compliance with all regulations surveyed.	{S 000}		

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