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
Stephanie Babb	10692	A. BUILDING: _____ B. WING _____	C 06/04/2026

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 licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 6/2/26 through 6/4/26. Key City Assisted Living, LLC was found not in compliance with the following requirements: S030, S096, S105, S166, S201, S275, S280, S295, S310, S330, S331, S335, S337, S352, S405, S415, S506, S620, S632, S670, and S685. A compliant survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 6/2/26 through 6/4/26. Area surveyed included potential abuse, potential neglect, resident rights, and nursing services. Key City Assisted Living, LLC was found not in compliance with the following requirement: S415.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report any of the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and or other critical equipment necessary for operation of the facility for more than twenty-four hours;.	S 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Benedict/Stephanie Babb — TITLE: Administrator/ Assistant admin — (X6) DATE: 07/19/2026

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S 030	Continued From page 1 (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation of the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to report abuse involving resident (8) threatening other residents. Findings include: 1. Review of resident 8's closed record revealed he was provided with an eviction notice on 2/15/26. Resident 8 was being evicted for "1. Threatening to club a resident over the head with your cane due to her sitting in the chair you wanted. 2. Threatening a resident with a pocketknife that you were going to castrate him. 3. Telling staff to put a blood pressure cuff around another resident's neck and making it tight as possible, 4. Calling several female residents and staff 'bitches'. 5. Having an altercation with a staff [member] over closing off a bathroom during cleaning and calling him a 'son of a bitch'. 6. Telling another resident and staff that you were going to knock them on their ass. 7. Telling staff that one day they were going to find your	S 030		

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S 030	Continued From page 2	S 030		

roommate lying on the floor bloody due to him talking on his cell phone. 8. Continuously making rude comments towards various other residents. 9. Continuously trying to get residents to engage in negativity towards the facility and management. 10. Continuing to have your room in disarray with clutter and garbage after being talked to numerous times about it being a fire and pest hazard. 11. Entering female residents' rooms after being advised that it is not allowed by your daughter and by management. 12. Having a verbal screaming altercation with a resident in the dining area due to him shaking his leg which was explained that it is a medical condition that he cannot control. 13. Damaging the door frame, breaking the outside railing, breaking the closet door off, breaking closet shelves, breaking [the] shower rod by pulling on it, running [your] electric chair into [the] building. 14. Making inappropriate sexual comments toward female staff and residents along with inappropriate comment[s] towards staff about body size and she shouldn't eat due to her weight."

2. Review of an unsigned statement documented on 2/16/26 revealed, "Presented [resident 8's name] with the Feb 15th dated letter advising him of the replacement due to ongoing issues within the facility and of him being so unhappy. He became very agitated and combative over the letter in the middle of the dining room. I explained to him that we could go off in private and discuss it but not in the middle of the dining room. We then went to his room. He proceeded to tell me that I was a liar about everything in the letter and that I was a manipulator. I tried to explain that I was not manipulating anyone and that I had never lied to him an also explained that everything in the letter were issues brought to me by other staff and residents and some I was able to pull the

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S 030	Continued From page 3 camera [footage] and verify but some I could not. He said everyone was lying and he had done nothing wrong and has tried to make everything work around there but that I didn't like him and was looking for things to get after him about and try to kick him out over and that I was a sick person for what I was doing to him. I told him that I on the contrary had went to bat for him and stuck up for him when I should have made state reports regarding his violent episodes but did not, to try and keep him in the facility but it was to the point that he was not happy there so I wanted to help find a place that he could be happy at. He again started yelling ...." 3. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training A revealed that she was the author of the note documented on 2/16/26. She knew she should have reported the threats of violence to other residents to the Department of Health. She tried to give resident 8 a chance. She agreed she should have reported the events to the Department of Health but did not do so.	S 030	The administrator will provide education to the staff along with the RN regarding incident requirements, reportable conditions, follow-up investigations, and applicable reporting procedures. The education will be: 1. proper completion of inciednt reports and where to completed reports are to be filed. 2. Documentation requirements in th EMR include: time of the incident, a summary of the incident, documentationn of family notification, including who was notified. details of any suspected injury, vitals, and documentation regarding any hospital transfer and the residents return to the facility. The RN or designee will aduit the incident report log weekly for four (4) weeks and then monthly for four (4) months to ensure compliance with incident reporting and documentation requirements. Audits will continue until compliance has been maintained for two (2) consecutive quarters. No new policies have been revised or created.	07/01/2026
S 096	44:70:02:05 Housekeeping Cleaning Methods And Equipment Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials.	S 096		

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S 096	Continued From page 4 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to label three of three buckets containing disinfecting wipes in three of three bathrooms. Findings include: 1. Observation on 6/2/26 at 8:50 a.m. revealed a white 2-gallon bucket on the floor of the public bathroom located near the dining room. The bucket had a lid on it that had wipes coming up out of the center. There was no label on the bucket to indicate what was in the bucket. 2. Interview on 6/2/26 at 10:00 a.m. with licensed practical nurse (LPN) D revealed: the bucket contained a disinfectant for wiping the hard surfaces in the bathroom. She did not know what the name of the disinfectant was. 3. Observation on 6/2/26 from 10:00 a.m. to 11:00 a.m. revealed there were two more unlabeled disinfectant buckets located in two more bathrooms. 4. Interview on 6/3/26 at 9:00 a.m. with co-owner/administrator in training A revealed she had purchased the disinfectant, buckets, and wipes as a package deal. There were no labels to place on the buckets. She was not aware that those buckets were to be labeled with the chemical that was in them.	S 096	All products/chemicals have been properly labeled No new policies have been revised or created The administrator or designee educated all staff on the proper labeling of all buckets, bottles and other chemicals containers to ensure each item is clearly identified with the correct label accordance with the facility policy. The administrator or designee will complete weekly audits for 4 weeks, then monthly (4) with results reviewed by the Quality assurance committee and monitoring continuing until compliance is maintained for 2 consecutive quarters.	07/06/2026
S 105	44:70:02:06 Food Service	S 105		

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S 105	Continued From page 5 Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, testing, and label review, the provider failed to maintain the can opener blade in a clean and sanitary manner, maintain the cleanliness of the exterior of the ventilation hood system located above the stove, store food off the floor in one of one dry storage closet, and use a food grade sanitizer for cleaning the dining room tables. Findings include: 1. Observation on 6/2/26 at 11:30 a.m. revealed the can opener blade had a moderate amount of black crusty residue covering the top half of the blade. The top exterior of the hood system, located above the stove, was covered in a greasy residue. 2. Interview on 6/2/26 at 11:40 a.m. with patient care assistant (PCA) E revealed that he did not know when the can opener blade was last cleaned. He had never cleaned it and had worked there for about a year. It was not on a cleaning schedule. He cleaned the counters and cooking surfaces daily while working in the kitchen. He was not aware of the grease residue on top of the ventilation hood system. That area was not on a	S 105	The kitchen staff immediately corrected the identified deficiencies. The can opener blade was removed, cleaned, sanitized and placed on the routine cleaning schedule of every day cleaning. The over the stove range hood was taken down and replaced on 07/12/2026 it will now be placed on the daily and weekly routine cleaning schedule. All food items stored on the floor in the dry storage closet were immediately removed and placed in approved food storage containers. The non-food grade cleaning products previously used on dining tables was discarded and replaced with an approved food-grade sanitizer. The administrator educated all kitchen and housekeeping staff on proper food sanitation practices, including maintaining clean food preparation equipment, keeping food stored off the floor, following routine kitchen cleaning schedules, and using only approved food-grade sanitizers on food contact surfaces. The administrator or disgnee will conduct weekly audits of the kitchen and dining areas for four(4) weks to verify compliance with sanitation, storage, and cleaning requirements. Audits will then be conducted monthly for four(4) additional months. Policy was revised to reflect required cleaning and sanitization.	~~06/10/2026~~ 07/12/26

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S 105	Continued From page 6 cleaning schedule. He agreed that both the can opener and top of the ventilation hood system needed cleaning. 3. Observation on 6/3/26 at 2:12 p.m. in the dry storage room revealed plastic grocery bags of food sitting on the floor. In the plastic bags there were two oranges in a plastic produce bag, one package of Always Save duplex sandwich cookies, one open and half used loaf of Sara Lee white whole grain bread, one sealed bag of corn chips, one open half empty bag of spicy fried pork skins, one open box of saltine crackers containing one sleeve of crackers, and one open box of Munchies sandwich crackers. There was also one case of eight-ounce bottles of Glucerna therapeutic nutrition, one case of eight-ounce bottles of Ensure nutrition shakes, and two bags of potatoes stored on the floor. 4. Interview on 6/3/26 at 4:00 p.m. with co-owner/administrator in training (AIT) A revealed that the two bags of potatoes were for the facility. All the other food belonged to a resident. The food was removed from the resident's room because of behavior issues with the resident creating a mess. She was not aware that all food, including the residents' food, was to be stored off the floor in a protected sanitary manner. 5. Observation on 6/3/26 at 2:30 p.m. in the dining room revealed PCA E had sprayed the dining room tables with a clear liquid from a spray bottle. He then wiped the tables clean. 6. Interview on 6/3/26 following the above observation with PCA E revealed the spray bottle was what they used to sanitize the tables between meals. He did not know what was in the	S 105		

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S 105	Continued From page 7 bottle, he had never mixed it before. 7. Observation and testing on 6/3/26 at 3:00 p.m. of the spray bottle used by PCA E revealed that it was labeled as Envirocide disinfectant. Testing of the contents of the bottle for chlorine and quaternary ammonia (common chemicals used for sanitizing or disinfecting surfaces) revealed the spray bottle did not contain either chemical. 8. Label review and interview on 6/3/26 at 4:00 p.m. with co-owner/AIT A revealed Envirocide disinfectant was a hospital grade quaternary ammonia disinfectant. It was not approved for use in food preparation facilities. Co-owner/AIT A was not aware that Envirocide disinfectant should not be used to disinfect food preparation or serving areas.	S 105	~~The~~	
S 166	44:70:02:17(1-2) Occupant Protection The facility shall: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to have a written preventative maintenance program. Findings include:	S 166		

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S 166	Continued From page 8 1. Observation and testing on 6/2/26 at 8:30 a.m. through 9:00 a.m. revealed that four of four fire extinguishers did not have monthly inspections documented (by the laundry room, in the kitchen, by room 7, and in the stairwell to the basement). Three of five emergency lights would not light when tested (front entrance, by room 1, and by room 5). The annual inspection for the fire alarm system was not completed for 2025. The annual and 5-year internal inspection for the fire sprinkler system was not completed for 2025. 2. Interview on 6/3/26 at 9:30 a.m. with co-owner/administrator in training A revealed she was not aware that the fire extinguishers were to be inspected and documented monthly. She was not aware that the emergency lights were to be tested and documented monthly. She was not aware that the fire alarm system was to be inspected annually. She was not aware that the fire sprinkler system was to be inspected annually and was to have an internal obstruction investigation every five years. She did not have a written preventative maintenance plan.	S 166	The administrator immediately developed and implented a written preventive maintenance policy that identifies all required inspections, testing and maintenace schedules for life safety equipment, including mothly fire extinguisher inspections, monthly emergency lighting tests, annual fire alarm inspections, annual fire sprinkler inspections. All fire extinguishers were inspected and initaled. The emergency lights that failed testing have had the batteries replaced and new ones ordered for the ones with out batteries. All lights will be tested monthly and documented. The annual fire alarm and sprinkler system will be inspected on July 27, 2026.	~~07/11/26~~ 07/19/26
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel.	S 201		

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S 201	Continued From page 9 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the emergency lighting, the fire extinguishers, the fire alarm system, and the fire sprinkler system. The provider also installed privacy curtains that would impede the fire sprinkler coverage in four of ten resident rooms (rooms 1, 3, 6, and 10). Findings include: 1. Observation and testing on 6/2/26 at 8:30 a.m. through 5:00 p.m. revealed that four of four fire extinguishers did not have monthly inspections documented (by the laundry room, in the kitchen, by room 7, and in the stairwell to the basement). Three of five emergency lights would not light when tested (front entrance, by room 1, and by room 5). The annual inspection for the fire alarm system was not completed for 2025. The annual and 5-year internal inspection for the fire sprinkler system was not completed for 2025. 2. Interview on 6/3/26 at 9:30 a.m. with co-owner/administrator in training (AIT) A revealed she was not aware that the fire extinguishers were to be inspected and documented monthly. She was not aware that the emergency lights were to be tested and documented monthly. She was not aware that the fire alarm system was to be inspected annually. She was not aware that the fire sprinkler system was to be inspected annually and was to have an internal obstruction investigation every five years. She did not have a written preventative maintenance plan. 3. Observation on 6/2/26 at 11:00 a.m. in room 6	S 201	The administrator has developed and implemented a wrtten preventive maintenance policy to ensure all required life safety equipment is inspected, test, maintained and documented according to manufacturer recommendations and applicable state and fire safety regulations. All fire extinguishers are to be inspected, properly tagged, and entered into a monthly inspection log. All emergency lighting units were tested, and those found to be non-functional were repaired or replaced. The facility has scheduled and will complete the required annual fire and sprinkler system by a licensed contrator on 07/27/26. Privacy curtains installed in residents rooms have been removed and new ones will be ordered and installed. No new policys revised but new documentation has been created to ensure compliance.	06/30/26

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S 201	Continued From page 10 revealed the privacy curtain installed between the two beds was solid to the ceiling and did not have the required eighteen inches of mesh at the top. The solid curtain would block the sprinkler coverage from reaching the other side of the room. 4. Interview on 6/3/26 at 9:30 a.m. with co-owner/AIT A revealed that the privacy curtains were installed a few weeks ago. She was not aware that privacy curtains were required to have a mesh opening at the top to allow the water from a sprinkler head to spray to the other side of the room. 5. Observation on 6/3/26 at 10:00 a.m. revealed that the same style of solid curtains were installed in rooms 1, 3, and 10. All three of those curtains would block the fire sprinkler coverage from reaching the other side of the rooms.	S 201		
S 275	44:70:04:01 Governing Board Each facility operated by a limited liability partnership, a corporation, or a political subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this chapter pertaining to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the governing body failed to manage the facility in a manner that ensured the overall daily management of the facility, appropriate resident	S 275		

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S 275	Continued From page 11 care, resident safety, and maintained compliance with the Administrative Rules of South Dakota (ARSD) 44:70 Assisted Living regulations. Areas of concern included the following: *Investigation, reporting, and implementation of resident-to-resident altercations. *Proper use of supplies and chemicals for cleaning. *Food safety and sanitation. *Occupant protection related to the lack of a preventative maintenance program. *Fire safety related to emergency lights, fire extinguishers, fire alarms, and sprinkler systems. *Personnel training. *Retention of a resident that exceeded the facility's license provisions. *Completion of tuberculin assessment, screenings, and education. *Documentation by direct care and licensed nurse staff. *Resident service plans. *Drug regimen reviews. *Medication labeling. *Self-administration of medication assessments. Findings include: 1. Interview with co-owner/administrator in training (AIT) A on 6/2/26 at 9:30 a.m. during the entrance conference revealed that she handled the day-to-day operations of the facility and was working on the completion of the state-approved administrator course. 2. Interview with co-owner/registered nurse (RN)/administrator B on 6/4/26 at 10:30 a.m. revealed she was the administrator on record but worked a full-time job outside of the facility and left the day-to-day operations to co-owner/AIT A. Co-owner/RN/administrator B tried to be at the	S 275	The Governing Body has implemented corrective actions to ensure effective oversight of facility operations and compliance with ARSD 44:70. A qualified Administrator now provides daily oversight, staff have been educated on revised policies, required documentation has been completed, and ongoing audits will be conducted weekly for four weeks, then monthly through the Quality Assurance to ensure continued compliance.	07/01/26

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	10692	A. BUILDING: _____ B. WING _____	C 06/04/2026

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 275	Continued From page 12 facility at least once a week but acknowledged that did not always occur. 3. Review of the 5/18/26 assisted living license renewal identified the governing body as having two members that consisted of co-owner/AIT A and co-owner/RN/administrator B. Refer to S030, S096, S105, S201, S295, S310, S330, S331, S335, S337, S352, S405, S415, S506, S620, S632, S670, and S685.	S 275		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the administrator failed to manage the facility in a manner that ensured the overall daily management of the facility, appropriate resident care, resident safety, and maintained compliance with the Administrative Rules of South Dakota (ARSD) 44:70 Assisted Living regulations. Areas of concern included the following: *Investigation, reporting, and implementation of resident-to-resident altercations. *Proper use of supplies and chemicals for cleaning.	S 280		

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S 280	Continued From page 13 *Food safety and sanitation. *Occupant protection related to the lack of a preventative maintenance program. *Fire safety related to emergency lights, fire extinguishers, fire alarms, and sprinkler systems. *Personnel training. *Retention of a resident that exceeded the facility's license provisions. *Completion of tuberculin assessment, screenings, and education. *Documentation by direct care and licensed nurse staff. *Resident service plans. *Drug regimen reviews. *Medication labeling. *Self-administration of medication assessments. Findings include: 1. Interview with co-owner/administrator in training (AIT) A on 6/2/26 at 9:30 a.m. during the entrance conference revealed that she handled the day-to-day operations of the facility and was working on the completion of the state-approved administrator course. 2. Interview with co-owner/registered nurse (RN)/administrator B on 6/4/26 at 10:30 a.m. revealed she was the administrator on record but worked a full-time job outside of the facility and left the day-to-day operations to co-owner/AIT A. Co-owner/RN/administrator B tried to be at the facility at least once a week but acknowledged that did not always occur. 3. An administrator job description was requested from co-owner/AIT A during the entrance conference on 6/2/26 at 9:30 a.m., but was not received by the conclusion of the survey.	S 280	The governing body has designated the co- owner and office manager to obtain the state approved administrator course to obtain the correct certificate of administrator then to represent the owner and assume responsibility for the daily overall management of the facility. A qualified designee will be appointed to act on behalf of the administrator during absences. The governing body will provide written notification to the Department of any change in administrator as required by ARSD 44:70 Assisted Living regulations. To address the identified concerns, the co-owner/ administrator in training has been re-educated on expectations related to: oversight of resident care, timely investigation and reporting of resident-to-resident altercations, and proper use, storage, and application of cleaning supplies and chemicals to ensure resident safety and regulatory compliance. The administrator or designee will conduct routine audits on all the above listed of incident reports and environmental cleaning practices to ensure compliance. Findings will be reviewed weekly for four weeks and monthly thereafter for three months. Results will be reported to the Quality Assurance (QA) committee for review and ongoing monitoring until sustained compliance is achieved.	07/02/26

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S 280	Continued From page 14 Refer to S030, S096, S105, S201, S295, S310, S330, S331, S335, S337, S352, S405, S415, S506, S620, S632, S670, and S685.	S 280		
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure ongoing annual education was provided on required topics for four of five sampled employees (C, D, E, and G). Findings include: 1. Review of employee C's personnel file revealed she was hired on 11/18/24 and was the business office manager (BOM)/registered medication aide (RMA). She had completed initial training on the required topics on 1/3/25. There was no documentation to support she completed ongoing annual training. 2. Review of employee D's personnel file revealed she was hired on 4/1/25 and was a licensed practical nurse (LPN). She had completed initial training on the required topics on 4/3/25. There was no documentation to support she completed ongoing annual training. 3. Review of employee E's personnel file revealed he was hired on 10/30/24 as a patient care	S 295		

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S 295	Continued From page 15 assistant (PCA). He had completed initial training on the required topics on 10/30/24 and 11/5/24. There was no documentation to support he completed ongoing annual training. 4. Review of employee G's personnel file revealed he was hired on 11/2/24 as an RMA. He had completed initial training on the required topics on 12/5/24. There was no documentation to support he completed ongoing annual training. 5. Interview on 6/3/26 at 8:45 a.m. with co-owner/administrator in training (AIT) A revealed that education on the required topics had occurred with employees following their hire date. However, the employees did not receive ongoing annual training on the required topics. Co-owner/AIT A was not aware that education on the required topics needed to be repeated on an annual basis. 6. A personnel training policy was requested from co-owner/AIT A on 6/3/26 at 5:00 p.m., but was not received by the conclusion of the survey.	S 295	The Administrator or designee will immediately complete a full audit of all staff training records to identify any additional deficiencies and ensure all required annual education topics are current. Any staff found out of compliance will complete the required training within 30 days, and new hires will receive updated orientation upon hire and prior to providing unsupervised care. To prevent recurrence, the Administrator or designee will implement a monthly training compliance audit and maintain a tracking log to ensure all required annual education is completed on schedule. Results of audits will be reviewed monthly and presented at t he quarterly QA committee meeting for ongoing monitoring and compliance assurance. Policies were changed to reflect required annual training. The survey team had been provided the employee book/binder during the survey. However, they were not able to locate the policy within the binder. The binder has been updated to reflect the personnel training policy at the front of the binder.	07/06/26
S 310	44:70:04:06 Admissions And Retention Of Residents The governing body of the facility shall establish and maintain admission, transfer, and discharge policies, with written evidence to assure the residents admitted to and retained in the facility are within the licensure classification of the facility or its distinct part. The facility may admit and retain, on the orders of a physician, physician assistant, or nurse practitioner, only those residents for whom it can provide care safely and effectively.	S 310		

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S 310	Continued From page 16 This Administrative Rule of South Dakota is not met as evidenced by: Based on license review, observation, care record review, interview, lease agreement review, and policy review, the provider failed to ensure one of five sampled residents (1) did not receive care that was more than the services and provisions listed on their license. Findings include: 1. Review of the provider's 7/1/25 provisional assisted living center license revealed they were able to accept and retain residents who required medication administration, were physically impaired, on supplemental oxygen, were enrolled in hospice services, and had cognitive impairment. In addition, the facility had a staffing exception that allowed for one staff member to be on duty. The facility was not licensed to provide care for residents requiring total assistance or who were not capable of self-preservation. 2. Observation on 6/2/26 at 10:15 a.m. during the facility tour revealed a mechanical sit-to-stand lift (a device used to assist a person from a seated to standing position) in resident 1's room with a sling draped over the device. 3. Observation on 6/2/26 at 11:30 a.m. in the living room area of the facility revealed resident 1 was sleeping in a recliner chair with her feet elevated. At 12:02 p.m. resident 1 was awoken and assisted to a sitting position by licensed practical nurse (LPN) D and business office manager (BOM)/registered medication aide (RMA) C. Resident 1 was then assisted to a standing position and took several steps for a pivot transfer (when assisted to a standing	S 310	Upon review of our current assisted living license, it was determined that the facility is not licensed to provide total-assistance services, including the use of a sit-to-stand lift. The sit-to-stand machine has been removed from the facility, and the Governing Body will ensure that only residents whose care needs are within the facility's licensed scope of services are admitted and retained. Resident 1 experienced a temporary decline in mobility; however, physician-directed medication adjustments along with PT and OT interventions were implemented, resulting in improvement to baseline status. Current PT/OT documentation confirms the resident is steady on her feet and able to safely participate in assisted transfers consistent with the facility's licensure level. The facility will continue to monitor for changes in condition and ensure timely reassessment and documentation to confirm ongoing compliance with admission and retention requirements.	07/06/26

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S 310	Continued From page 17 position, the resident turns their body to move to another surface) to her wheelchair. She provided minimal assistance and relied heavily on the two staff members on each side of her to pivot. 4. Review of resident 1's care record revealed she admitted to the facility on 5/1/19. Her 4/15/26 mini-mental status evaluation (MMSE) revealed a score of 20 out of 30, which indicated her cognition was moderately impaired. Her diagnoses included congestive heart (a condition where the heart is too weak to pump efficiently), hypertension (high blood pressure), dysphagia (difficulty swallowing), and type II diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar). Her most recent service plan, dated 5/25/23, revealed she used a walker for ambulation (walking) and was able to move throughout the community. Resident 1's progress notes and evaluations did not identify a change in condition. 5. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training (AIT) A and co-owner/registered nurse (RN)/administrator B revealed that resident 1 had a hospitalization in May 2025 and experienced a significant change in condition. Co-owner/RN/administrator B acknowledged that there was nothing in her care record to indicate that she had a change in condition or was hospitalized. Co-owner/RN/administrator B stated that the administrator and RN at the time of the change of ownership two years prior had told her that it was not necessary to document progress notes or changes in condition in the resident's care record. Except for scheduled evaluation of resident needs, there was no progress notes or change in condition documentation for any resident in their	S 310		

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S 310	Continued From page 18 care record. Co-owner/AIT A acknowledged there was a mechanical sit-to-stand lift in resident 1's room; however, it was not used yet by the staff. Co-owner/AIT A and BOM/RMA C had received education from the hospital staff regarding the use of the mechanical lift. Co-owner/AIT A and BOM/RMA C did not provide education or perform competencies with the facility staff. Co-owner/AIT A and co-owner/RN/administrator B acknowledged that resident 1 was not capable of self-preservation if an emergent event occurred. They acknowledged there was only one staff member on duty between the hours of 7:00 p.m. and 7:00 a.m. and that resident 1 often required the assistance of two staff members. Resident 1 did have a family member that was involved in her care, but the facility did not begin resident 1's discharge planning yet, although she needed a higher level of care. 6. Review of the lease agreement signed updated by resident 1 on 8/1/24 revealed, "To qualify to be a resident of [name of facility], the resident must: 1. Be able to hear alarms and self-evacuate in an emergency. 2. Require no more than one (1) person assist....5. Require any care or services beyond our current licensure. [Name of facility] is not a skilled nursing home or a memory care facility nor should it be construed as such, even on a temporary basis." 7. Review of the provider's 2024 Admission/Discharge Criteria policy revealed, "[Name of facility] will not admit or retain residents who require care in excess of our specific license. Our facility may not admit or retain:...4. Those who are unable to exit the building in an	S 310		

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S 310	Continued From page 19 emergency with minimal assistance of one staff person."	S 310		
S 330	44:70:04:10 Tuberculin Screening... Requirements Each facility shall develop criteria to screen healthcare personnel and residents for Mycobacterium tuberculosis (TB) based on the Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. Each facility shall establish policies and procedures for conducting TB risk assessment that include the key components of responsibility, surveillance, and containment. The frequency of repeat screening depends upon annual facility risk assessment results. Any resident identified as asymptomatic upon admission as short stay or anticipated stay of thirty days or less is not required to have a tuberculin skin test or a TB blood assay test. 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 the annual tuberculosis (TB) facility risk assessment was completed. Findings include: 1. A copy of the annual TB facility risk assessment was requested along with other documents during the entrance conference with co-owner/administrator in training (AIT) A and business office manager (BOM)/registered medication aide (RMA) C on 6/2/26 at 9:30 a.m.	S 330		

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S 330	Continued From page 20 This document was not received on 6/2/26 and a copy was again requested to co-owner/AIT A on 6/3/26 at 8:30 a.m. 2. Interview on 6/3/26 at 10:05 a.m. with co-owner/AIT A and BOM/RMA C revealed the assessment was not been completed and they did not realize it was a requirement. The annual TB facility risk assessment was not completed since the change of ownership on 6/12/24. 3. Interview on 6/4/26 at 10:30 a.m. with co-owner/registered nurse (RN)/administrator B revealed she was unaware of the annual TB facility risk assessment requirement. 4. Review of the provider's 2024 Required TB Testing and Recommended Vaccinations policy revealed, "A facility nurse will complete the annual TB risk assessment using guidelines issued by [the] Centers for Disease Control and Prevention. The completed assessment will be forwarded to the administrator, the administrator and nurse will interpret the results of the assessment."	S 330	The facility has completed the annual Tuberculosis (TB) risk assessment in accordance with the CDC/National Tuberculosis Controllers Association 2019 guidelines. Documentation of the completed risk assessment has been finalized and is maintained on file at the facility for review. The assessment was used to determine the facility's TB risk category and to establish the appropriate screening and testing frequency for both residents and healthcare personnel. The Administrator or designated staff member is responsible for ensuring the TB risk assessment is completed annually, documented appropriately, and used to guide ongoing TB screening, surveillance, and infection control practices. Policies have been revised to reflect changes	07/15/26
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of	S 331		

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S 331	Continued From page 21 admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of five sampled employees (D and F) and one of five sampled residents (2) received a tuberculin (TB) two-step skin test or blood assay test within twenty-one days of employment or admission, or provided evidence of a negative TB test in the twelve months before employment or admission. Findings include: 1. Review of the personnel record for employee D revealed she was hired on 4/1/25 as a licensed	S 331	We have completed the TB screening for employee D, F, and resident 2. All staff and residents have been reviewed to ensure that a TB screen/test have been completed. We have it added to our admission checklist. The facility has developed and implemented a Tuberculosis (TB) screening policy in accordance with the CDC/National Tuberculosis Controllers Association 2019 recommendations. The policy includes defined procedures for TB risk assessment, staff responsibility, surveillance, and infection control containment measures. All healthcare personnel and residents are screened based on the facility's annual TB risk assessment to determine the appropriate frequency of testing. Effective immediately, the facility ensures that TB screening is completed within 21 days of hire for staff and 21 days of admission for residents. The facility LPN/RN are responsible for ensuring compliance, documentation, and ongoing monitoring of TB screening requirements.	07/19/26

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S 331	Continued From page 22 practical nurse (LPN). A quantiferon TB Gold blood test had a negative result when completed on 7/13/20. There was no documentation in her personnel record to support that she was tested for TB within the twelve months before or within twenty-one days of her employment. 2. Review of the personnel record for employee F revealed he was hired on 8/12/25 as a registered medication aide (RMA). A two-step TB skin test was completed with a previous employer on 1/31/23 and 2/8/23. There was no documentation in his personnel record to support that he was tested for TB within the twelve months before or within twenty-one days of his employment. 3. Review of the care record for resident 2 revealed was admitted to the facility on 2/20/25. A two-step TB skin test was completed on 3/19/25 and 3/22/25. The first step was completed twenty-seven days after his admission. There was no documentation to support that was tested for TB within the twelve months before admission or within twenty-one days of his admission. 4. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training (AIT) A and co-owner/registered nurse (RN)/administrator B revealed they were not aware that a TB test before a resident's admission or an employee's hire date had to be completed within the previous twelve months. They had thought a previous negative result was adequate for an indefinite time. Co-owner/AIT A and co-owner/RN/administrator B were not able to provide additional information on why resident 2's TB screening had not been completed on time. The licensed nurse was responsible for the completing the TB screening and testing for resident admissions and newly hired employees.	S 331		

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S 331	Continued From page 23 5. Review of the provider's 2024 Required TB Testing and Recommended Vaccinations policy revealed, "Each new resident or new staff person must have a two-step Mantoux TB lest [test] within 21 days of admission or employment. The Registered Nurse or Manager will set-up and monitor the completion of any required TB testing for new employees and residents. A community nurse will work with the Manager to assure [ensure] all required testing is completed. Any two documented TB tests completed within 12 months prior to admission or employment will be considered a 2 step."	S 331		
S 335	44:70:04:10.01 TB Education for Healthcare Personnel All healthcare personnel shall receive TB education annually. TB education shall include information on TB risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures of the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure four of six sampled employees (C, D, E, and G) completed the required tuberculosis (TB) training annually. Findings include: 1. Review of employee C's personnel file revealed she was hired on 11/18/24 and was the business office manager (BOM)/registered medication aide (RMA). She had completed initial TB training on 1/3/25. There was no documentation that she completed ongoing	S 335		

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	10692	A. BUILDING: _____ B. WING _____	C 06/04/2026

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S 335	Continued From page 24 annual TB training. 2. Review of employee D's personnel file revealed she was hired on 4/1/25 and was a licensed practical nurse (LPN). She had completed initial TB training on 4/3/25. There was no documentation that she completed ongoing annual TB training. 3. Review of employee E's personnel file revealed he was hired on 10/30/24 as a patient care assistant (PCA). He had completed initial TB training on 10/30/24 and 11/5/24. There was no documentation that he completed ongoing annual TB training. 4. Review of employee G's personnel file revealed he was hired on 11/2/24 as a RMA. He had completed initial TB training on 12/5/24. There was no documentation that he completed ongoing annual TB training. 5. Interview on 6/3/26 at 8:45 a.m. with co-owner/administrator in training (AIT) A revealed that education on the required topics had occurred with employees following their hire date. However, employees did not receive ongoing annual training. Co-owner/AIT A was not aware that education needed to be repeated on an annual basis. 6. A personnel training policy was requested from co-owner/AIT A on 6/3/26 at 5:00 p.m., but was not received by the conclusion of the survey.	S 335	The facility has implemented an annual Tuberculosis (TB) education program for all healthcare personnel in accordance with CDC guidelines and state requirements. The training includes TB transmission, signs and symptoms, screening procedures, infection control measures, and reporting protocols. Documentation of completed TB education is maintained in each employee's personnel file. Effective immediately, all healthcare personnel are required to complete TB education upon hire and annually thereafter. The Administrator or designated staff member is responsible for ensuring compliance, tracking completion, and maintaining accurate training records to verify that all staff have met annual TB education requirements. All employees C,D,E,and G were brought up to date on their TB education. As were all other staff. We will continue to have annual training as it was an annual training. No policies changed or renewed.	07/08/26
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted	S 337		

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S 337	Continued From page 25 standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, care record review, and interview, the facility failed to include documentation in the care record for one of five sampled residents (1) who had a significant change in condition. Findings include: 1. Observation on 6/26/26 at 10:15 a.m. during the facility tour revealed a mechanical sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) in resident 1's room with a sling draped over the device. 2. Observation on 6/2/26 at 12:02 p.m. in the living room area of the facility revealed resident 1 was awoken and assisted to a sitting position by licensed practical nurse (LPN) D and business office manager (BOM)/registered medication aide (RMA) C. Resident 1 was then assisted to a standing position and took several steps for a pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) to her wheelchair. She provided minimal assistance and relied heavily on the two employees on each side of her to pivot. 3. Review of resident 1's care record revealed she admitted to the facility on 5/1/19. Her diagnoses included congestive heart failure (a condition where the heart is too weak to pump efficiently), hypertension (high blood pressure), dysphagia (difficulty swallowing), and type II	S 337		

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S 337	Continued From page 26 diabetes mellitus (a condition with disruptions in how the body regulates blood sugar). Her most recent service plan dated 5/25/23 revealed she used a walker for ambulation (walking) and was able to move throughout the community. Resident 1's progress notes and evaluations in the care record did not identify a change in condition. 4. Review of resident 1's section in the facility communication binder revealed an unknown caregiver had handwritten the following note on 5/6/26 at an unknown time, "Was unable to get her to wake up fully to take meds [medications]. [Name of caregiver] helped @ [at] 9:30 a.m. to sit her up gave her meds as she is still trying to sleep. Laid back down unable to fully wake up. Got up for lunch ate all lunch went to take her to the recliner got her situated in [the] recliner and she ended up puking all over herself and the chair gave her a bath ended up getting sick in the shower called ambulance sent her to ER [emergency room]." There were no entries for resident 1 in the facility communication book until an unknown caregiver wrote on 5/22/26, "Back from hospital!" There was no documentation that the resident's physician had been notified, or that a licensed nurse assessed the resident before or after her change in condition and return from the hospital. 5. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training (AIT) A and co-owner/registered nurse (RN)/administrator B revealed that with the exception of a scheduled evaluation of resident needs, there was no documentation for any resident by the licensed nurse in their care record. Co-owner/RN/administrator B stated that the administrator and RN at the time of the change of	S 337	The Administrator and RN have educated staff on the following procedures: they will document in PCC and daily progress report book The resident's provider will be notified of any change in condition by the RN, Administrator, or designee within 24 hours via telephone or fax. The resident's family member and/or Power of Attorney (POA) will be notified immediately by the RN, Administrator, or designee of any significant change in the resident's condition. The RN will document all provider orders and instructions outlining any resident-specific care requirements and interventions. The Administrator, RN, or designee will provide ongoing education to all staff on a monthly basis regarding: Resident-specific care instructions provided by the RN When staff are required to notify the RN, provider, Administrator, and family/POA of changes in a resident's condition. The location and use of resident-specific care instructions. Copies of these instructions will be maintained in the binder located in the medication room for staff reference. The facility's resident fall and accident protocol. A current copy of the facility's Policy and Procedure manual is available in the medication room for staff review. No new revisions or policies created. Current ones being enforced.	07/11/26

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S 337	Continued From page 27 ownership two years prior had told her that it was not necessary to document progress notes or changes in condition in the resident's care record. Co-owner/AIT A and co-owner/RN/administrator/B verbalized that the direct care staff did not document in the residents' care record. The notes completed by the direct care staff completed resident notes in the communication binder. They acknowledged that the notes made in the communication binder frequently lacked accurate dates, times, or identification of the staff member who completed the communication note. In addition, the communication binder notes did not include when the licensed nurse/facility administration, physician, and family were notified of a change in condition. 6. A documentation policy was requested from co-owner/AIT A on 6/3/26 at 5:00 p.m., but was not received by the conclusion of the survey.	S 337		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to evaluate and document the care needs of one of five sampled residents (3) thirty days after his admission.	S 352		

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S 352	Continued From page 28 Findings include: 1. Review of resident 3's care record revealed he admitted to the facility on 4/15/26. His diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), type II diabetes mellitus (a condition with disruptions in how the body regulates blood sugar), and cardiac murmur (turbulent blood flow through the heart). An admission evaluation of care needs was completed on 4/17/26. There was no documentation that an evaluation of care needs had been completed thirty days following his admission. 2. Interview on 6/4/26 at 10:30 a.m. with co-owner/registered nurse (RN)/administrator B revealed that the licensed nurse was to have completed the evaluation of resident needs. Co-owner/RN/administrator B acknowledged that she was behind on the resident evaluations and assessments as she worked as an RN at a nearby hospital and that limited her onsite availability at the facility. Licensed practical nurse (LPN) D was assisting with the resident evaluations. Co-owner/RN/administrator B acknowledged that the evaluation was not completed for resident 3 thirty days after his admission. 3. Review of the provider's 2024 Resident Evaluations/Care Plans policy revealed, "Through regular evaluation and care plans, residents changing needs will be monitored. Resident Evaluation forms will be completed by the Resident Care Manager or his/her designee at admission, 30 days after admission, and at least annually thereafter."	S 352	The required 30-day resident evaluation has been completed for Resident #3. A comprehensive audit of all resident records was conducted to ensure admission, 30-day, and annual evaluations are current, and any missing assessments were completed immediately. T he Resident Care Manager, Licensed Nurse, or designee will be responsible for completing all required evaluations according to the facility policy. A tracking system has been implemented to monitor assessment due dates, and the RN or designee will perform monthly audits to verify compliance with South Dakota Administrative Rules and the facility's Resident Evaluations/ Care Plans policy. No revisions were made. Current ones will be enforced	07/11/26

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S 405	Continued From page 29	S 405	The facility has reviewed and revised all resident care plans/service plans identified during the survey to ensure they accurately reflect each resident's current medical, physical, mental, emotional, and personal care needs. Care plans have been updated to include all required interventions, including transfer assistance, oxygen use, fluid restrictions, and other individualized care need as applicable. To prevent recurrence, the Administrator and nursing staff will review all new admissions, significant changes in condition, and quarterly assessments to ensure care plans are completed and updated timely. A standardized care plan audit tool has been implemented, and the Administrator or designee will audit 100% of resident care plans monthly for three months to verify continued compliance. Any discrepancies identified will be corrected immediately, and staff will receive additional education as needed.No revision or no new ones created just our policies enforced.	07/10/26
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, care record review, interview, and policy review, the provider failed to develop and revise individual resident service plans to reflect the individual needs of four of five sampled residents (1, 2, 3, and 4). Findings include: 1. Observation on 6/2/26 at 12:02 p.m. of resident 1 receiving assistance with a pivot transfer from licensed practical nurse (LPN) D and business office manager (BOM)/registered medication aide (RMA) C revealed she required the assistance of two staff members to pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) to a wheelchair. Resident 1's ability to participate in the transfer was minimal and she only took a few steps. 2. Observation and interview on 6/3/26 at 8:30 a.m. with resident 2 revealed he was on oxygen delivered by a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) and was placed on a fluid restriction. 3. Review of resident 1's care record revealed	S 405		

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S 405	Continued From page 30 she admitted to the facility on 5/1/19. Her diagnoses included congestive heart failure (a condition were the heart is too weak to pump efficiently), hypertension (high blood pressure), dysphagia (difficulty swallowing), and type II diabetes mellitus (a condition with disruptions in how the body regulates blood sugar). Her most recent service plan dated 5/25/23 indicated she used a walker for ambulation (walking) and was able to move throughout the community independently. 4. Review of resident 2's care record revealed he admitted to the facility on 2/20/25. His diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), urinary retention, hypertension, and type II diabetes mellitus. His undated service plan for oxygen use indicated, "Uses oxygen. Directions (specify storage, maintenance, and provider)." It did not identify the oxygen setting parameters or if it was continuous or as-needed. The service plan did not indicate the resident was on a fluid restriction. 5. Review of resident 3's care record revealed he admitted to the facility on 4/15/26. His diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), type II diabetes mellitus, and cardiac murmur (turbulent blood flow through the heart). A 30-day notice was issued to him on 5/27/26 indicating that he was being discharged from the facility related to his behavior which included failure to maintain cleanliness and sanitation in his room, vaping (an aerosol device used to inhale a solution that often contains nicotine and other flavorings) inside the building, disrespectful behavior towards staff members, vulgar language used in the presence of others, and the inability to	S 405		

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S 405	Continued From page 31 follow facility rules and policies despite multiple reminders. His undated service plan did not address his adjustment to the facility, mood, or behavior. 6. Review of resident 4's care record revealed he admitted to the facility on 3/21/24. His diagnoses included type II diabetes mellitus, hypertension, and chronic kidney disease (a condition where the kidneys cannot filter properly). Review of his June 2026 medication administration record indicated he was able to self-administer his oral and injectable medications. His medications included amlodipine (treats high blood pressure) 10 milligrams (mg) daily, aspirin (blood thinner, stroke prevention) 81 mg daily, atorvastatin (treats high cholesterol) 80 mg daily, lisinopril (treats high blood pressure) 40 mg daily, vitamin D3 one capsule per week, and acetaminophen (treats pain or fever) 325-650 mg as needed every six hours. Review of his undated service plan indicated he was able to independently administer his insulin (a medication used to lower blood glucose levels) and blood glucose monitoring. It did not address his other medications that he was self-administering. 7. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training (AIT) A and co-owner/registered nurse (RN)/administrator B revealed that the administrator and RN at the time of the change of ownership two years prior had told co-owner/RN/administrator B that it was not necessary to document progress notes and changes in condition in the resident's care record. With the exception of a scheduled evaluation of	S 405		

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S 405	Continued From page 32 resident needs, there was no documentation for any resident in their care record. This included the resident service plans. They acknowledged that the service plans of the above residents did not reflect their individual needs. 8. Review of the provider's 2024 Resident Evaluations/Care Plans policy revealed, "A care plan will be constructed upon admission, 30 days after admission, and biyearly thereafter. An evaluation and care plan will also be done upon a resident's change in condition."	S 405		
S 415	44:70:05:03 Resident Care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, care record review, interview, job description review, and policy review, the provider failed to ensure the individual care needs of two of five sampled residents (1 and 2) were assessed and documented by licensed nursing staff related to their medical condition.	S 415		

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S 415	Continued From page 33 Findings include: 1. Observation on 6/26/26 at 10:15 a.m. during the facility tour revealed a mechanical sit-to-stand lift (a mechanical lift used to assist from a seated to standing position) in resident 1's room with a sling draped over the device. 2. Observation on 6/2/26 at 12:02 p.m. in the living room area of the facility revealed resident 1 was awoken and assisted to a sitting position by licensed practical nurse (LPN) D and business office manager (BOM)/registered medication aide (RMA) C. Resident 1 was then assisted to a standing position and took several steps for a pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) to her wheelchair. She provided minimal assistance and relied heavily on the two staff members on each side of her to pivot. 3. Review of resident 1's care record revealed she had been admitted to the facility on 5/1/19. Her diagnoses included congestive heart failure (a condition where the heart is too weak to pump efficiently), hypertension (high blood pressure), dysphagia (difficulty swallowing), and type II diabetes mellitus (a condition with disruptions in how the body regulates blood sugar). Her most recent service plan dated 5/25/23 indicated she used a walker for ambulation (walking) and was able to move throughout the community. Resident 1's progress notes and evaluations in the care record did not identify a change in condition. 4. Review of resident 1's section in the facility communication binder revealed an unknown caregiver had handwritten the following note on 5/6/26 at an unknown time, "Was unable to get	S 415	The Co-Owner/Administrator met with the facility RN and LPN to review and reinforce expectations regarding timely completion of resident assessments, documentation of resident visits, changes in condition, and care plan updates in accordance with facility policy and South Dakota Assisted Living regulations. The RN and LPN were educated that all required documentation must be completed promptly following resident visits or any significant change in condition. The Administrator/Co-Owner will conduct weekly audits of resident records for four (4) weeks to verify required documentation is completed accurately and timely, followed by monthly audits for three (3) months. Audit findings will be reviewed with the RN and LPN, and any deficiencies will be corrected immediately with additional education provided as needed. The facility policy regarding nursing documentation, resident assessments, and care plan oversight was reviewed and revised to clarify documentation timeframes, staff responsibilities, and the monitoring process to ensure ongoing compliance. This addresses all three of the surveyor's questions: Ongoing oversight: Weekly audits for 4 weeks, then monthly for 3 months, corrective action and education. LPN involvement: States the LPN was educated and is expected to complete documentation within her scope. Policies: Indicates the policy was reviewed and revised to clarify expectations and monitoring.	07/06/26

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S 415	Continued From page 34 her to wake up fully to take meds [medications]. [Name of caregiver] helped @ [at] 9:30 a.m. to sit her up gave her meds as she is still trying to sleep. Laid back down unable to fully wake up. Got up for lunch ate all lunch went to take her to the recliner got her situated in [the] recliner and she ended up puking all over herself and the chair gave her a bath ended up getting sick in the shower called ambulance sent her to ER [emergency room]." There were no entries for resident 1 in the facility communication book until an unknown caregiver wrote on 5/22/26, "Back from hospital!" There was no documentation that the licensed nurse was notified or had assessed the resident before or after her change in condition and return from the hospital. 5. Observation and interview on 6/3/26 at 8:30 a.m. with resident 2 revealed he was on oxygen delivered by nasal cannula, was on a fluid restriction, and had a catheter (flexible tubing placed in the bladder to drain urine) in place with the bag visible. 6. Review of resident 2's care record revealed he admitted to the facility on 2/20/25. His diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), urinary retention, hypertension, and type II diabetes mellitus. His undated service plan for oxygen use did not identify oxygen setting parameters, that he had a fluid restriction, and contained only minimal information related to a catheter. Resident 2's progress notes and evaluations did not identify information related to his oxygen use, catheter, or fluid restriction.	S 415		

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S 415	Continued From page 35 The physician and mid-level provider progress notes indicated he was sent to the emergency room or hospitalized several times for hypoxemia (low level of oxygen in the blood) or pneumonia (an infection within the air sacs of the lungs) in 2025 and 2026. There was no documentation from the licensed nurse of the resident 2's condition before or after he received treatment outside of the facility. His 2/20/25 admission evaluation indicated that he had used a catheter. A physician progress note on 12/15/25 indicated that a suprapubic catheter (a flexible tubing surgically placed through the abdomen into the bladder to drain urine) was placed. There was no documentation by the licensed nurse before or after the placement of the suprapubic catheter related to the reason for the change and his condition before or after the suprapubic catheter placement. Resident 2's order summary report indicated a 5/19/26 order for "one eight ounce glass of water at breakfast, lunch, supper, and bedtime. No other fluids while on restriction." There was no documentation by the licensed nurse regarding the resident's condition before and after the fluid restriction was ordered. 7. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training (AIT) A and co-owner/registered nurse (RN)/administrator B revealed that with the exception of a scheduled evaluation of resident needs, there was no progress note or change in condition documentation for any resident by the licensed nurse in their care record. Co-owner/RN/administrator B stated that the administrator and RN at the time of the change of	S 415		

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S 415	Continued From page 36 ownership two years prior had told her that it was not necessary to document progress notes or changes in condition within the resident's care record. 8. Review of the facilities undated Registered Nurse - Senior Care Nurse job description revealed, "The role of the Assisted Living Senior Care Registered nurse at [name of facility] is to ensure that the health and safety of all residents are met through assessments and reassessment, development and implementation of appropriate service plans and plans of care, monitoring of resident's services, supervision of all medical staff, including LPN, Medaides [medication aides] and other medical staff if appropriate." 9. 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. Any concerns noted by the nurse during the weekly review will be addressed with the Administrator and Managers." 10. Review of the provider's September 2024 Nursing Assessments policy revealed, "...The nurse will maintain proper auditing documentation on assessments and any status changes."	S 415		
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects:	S 506		

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S 506	Continued From page 37 (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure that four of five sampled employees (C, D, E, and G) completed ongoing annual dietary training on required topics. Findings include: 1. Review of employee C's personnel file revealed she was hired on 11/18/24 and was the business office manager (BOM)/registered medication aide (RMA). She had completed initial training on the required dietary topics on 1/3/25. There was no documentation that she completed ongoing annual dietary training. 2. Review of employee D's personnel file revealed she was hired on 4/1/25 and was a licensed practical nurse (LPN). She had completed initial dietary training on the required topics on 4/3/25. There was no documentation she completed ongoing annual dietary training. 3. Review of employee E's personnel file revealed	S 506	The facility has implemented a process to ensure all healthcare personnel providing dietary and food-handling services complete the required dietary in-service training within 30 days of hire and annually thereafter. Required training topics have been incorporated into the facility's new employee orientation and annual education program. Documentation of completed training will be maintained in each employee's personnel file. The Administrator or designee has revised the employee education and training policy to include the required dietary in-service training timeframes and documentation requirements. To ensure ongoing compliance, the Administrator or designee will conduct monthly audits of 100% of personnel files to verify required dietary training has been completed and documented. Audit findings will be reviewed, and any deficiencies will be corrected immediately through follow-up training and documentation. All staff and new hire have done annual education and training including C,D,E,and G.	07/11/26 07/19/26

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S 506	Continued From page 38 he was hired on 10/30/24 as a patient care assistant (PCA). He had completed initial dietary training on the required topics on 10/30/24 and 11/5/24. There was no documentation he completed ongoing annual dietary training. 4. Review of employee G's personnel file revealed he was hired on 11/2/24 as a RMA. He had completed initial dietary training on the required topics on 12/5/24. There was no documentation he completed ongoing annual dietary training. 5. Interview on 6/3/26 at 8:45 a.m. with co-owner/administrator in training (AIT) A revealed that it was that she expected all employees complete the required dietary training. Education on the required dietary topics had occurred with employees following their hire date. However, employees did not receive ongoing annual dietary training on the required topics. Co-owner/AIT A was not aware that education on the required dietary topics needed to be repeated on an annual basis. 6. A personnel training policy was requested from co-owner/AIT A on 6/3/26 at 5:00 p.m., but was not received by the conclusion of the survey.	S 506		
S 620	44:70:07:03 Medication Therapy Reviewed Monthly The pharmacist shall review the drug regimen monthly of each resident who requires administration of medications. The pharmacist shall review the resident's diagnosis, the drug regimen, and any pertinent laboratory findings and dietary considerations.	S 620		

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S 620	Continued From page 39 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 the pharmacy had reviewed six of six sampled residents' care records (1, 2, 3, 4, 5, and 6) monthly for diagnoses, medication regimen, pertinent laboratory studies, and dietary considerations. Findings include: 1. Review of resident 1's care record revealed she admitted to the facility on 5/1/19 and was a current resident. Her pharmacy reviews were completed monthly until 5/29/25. There was no documentation that a monthly pharmacist review was completed from June 2025 to the date of the survey. 2. Review of resident 2's care record revealed he admitted to the facility on 2/20/25 and was a current resident. His pharmacy reviews were completed monthly until 5/28/25. There was no documentation that a monthly pharmacist review was completed from June 2025 to the date of the survey. 3. Review of resident 3's care record revealed he admitted to the facility on 4/15/26 and was a current resident. There were no monthly pharmacist reviews completed for that resident. 4. Review of resident 4's care record revealed he admitted to the facility on 3/21/24 and was a current resident. His pharmacy reviews were completed monthly until 5/29/25. There was no documentation that a monthly pharmacist review was completed from June 2025 to the date of the	S 620	The facility acknowledges the deficient practice and has taken corrective action to ensure compliance. The consulting pharmacy will complete all overdue monthly medication regimen reviews for each resident, and the completed reviews will be placed in the monthly medication review binder. Effective immediately, the Administrator and Registered Nurse will maintain a monthly tracking log to verify that a pharmacist medication regimen review has been completed for every resident, filed in the monthly medication binder and that any pharmacist recommendations have been reviewed and acted upon as appropriate. The Administrator will audit 100% of resident records monthly to verify completion and documentation of pharmacist reviews. Audits will be conducted monthly for three months, then quarterly thereafter to ensure ongoing compliance. The existing Medication Management policy was reviewed and revised to include the monthly tracking and audit process to ensure pharmacist medication regimen reviews are completed timely and maintained in accordance with South Dakota Administrative Rules.	07/15/26

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S 620	Continued From page 40 survey. 5. Review of resident 5's care record revealed she admitted to the facility on 10/30/24 and was a current resident. Her pharmacy reviews were completed monthly until 5/29/25. There was no documentation that a monthly pharmacist review was completed from June 2025 to the date of the survey. 6. Review of resident 6's care record revealed she was admitted to the facility on 2/11/26 and discharged on 4/29/26. There were no monthly pharmacist reviews completed for resident 6. 7. Interview on 6/3/26 at 10:05 a.m. with co-owner/administrator in training (AIT) A and business office manager (BOM)/registered medication aide (RMA) C revealed that their consultant pharmacist had taken a maternity leave following the May 2025 pharmacist reviews. BOM/RMA C had alerted co-owner/AIT A that a substitute would need to be found to cover the reviews during the consultant pharmacist's maternity leave. Co-owner/AIT A acknowledged that she did not find a substitute. The pharmacist reviews did not resume at the facility following the consultant pharmacist's return from maternity leave. Co-owner/AIT A and BOM/RMA C acknowledged that the pharmacist reviews should have been completed monthly, and that did not occur. 8. Review of the provider's January 2023 Pharmacy Reviews policy revealed, "....will contract with a licensed pharmacist to review the drug regimen at least monthly for those residents requiring medication administration. The pharmacist will document the monthly review in the 'Pharmacy Reviews' binders in the staff	S 620		

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S 620	Continued From page 41 offices. The Nurse, Administrator, or designee will monitor to assure [ensure] that the medication reviews are completed on a monthly basis."	S 620	s632 : The facility corrected the deficiency by removing, verifying, and properly labeling the three insulin pens. The RN/designee audited all medications in the medication refrigerator for proper labeling and storage. Staff were re-educated on medication labeling and storage requirements. Monitoring: The RN or designee will complete weekly medication storage audits for 4 weeks, then monthly for 3 months. Audits will include all medications in the medication refrigerator to verify resident name, medication label, directions, and expiration dates. Any concerns will be corrected immediately. Policies were reenforced	7/11/26
S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure three insulin pens were labeled in one of one medication refrigerator for one of one sampled resident (3) who had a physician's order for insulin. Findings include: 1. Observation and interview on 6/3/26 at 1:30 p.m. with licensed practical nurse (LPN) D in the medication room revealed there was a sealed disposable bag containing three Lantus (insulin	S 632		

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S 632	Continued From page 42 glargine, long-acting) pens in the medication refrigerator. Resident 3's first name was written in marker on the bag. There was no label on the bag or insulin pens that indicated who the medication was prescribed to, the medical provider that prescribed the medication, how much medication was to be dispensed with each administration, how often the medication was to be administered, or when the medication was dispensed from the pharmacy. LPN D stated that the medication was sent from the veterans affairs (VA) pharmacy in that manner. She agreed that resident 3's first name written on the bag was not adequate for medication labeling. 2. Review of resident 3's June 2026 medication administration record revealed he was prescribed insulin glargine to be administered at 15 units subcutaneously (into the fatty layer of tissue under the skin) once a day in the morning. 3. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training (AIT) A and co-owner/registered nurse (RN)/administrator B revealed they agreed that the medication came from the pharmacy without being labeled, and the facility should have been contacted the pharmacy when it had arrived. 4. Review of the provider's 2024 Medication Storage policy revealed, "All containers must be labeled by a licensed pharmacist or physician with the resident's name, drug name and strength, practitioner's name, directions for use, and prescription date."	S 632		

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S 670	Continued From page 43	S 670	The Administrator/designee will be responsible for verifying completion of all medication aide training and ensuring the training tracking log remains accurate and current. The RN will provide and document required medication administration training, and the Administrator will audit training records quarterly to ensure compliance. The Medication Administration Training policy was reviewed and revised to include tracking, verification of completion, and ongoing monitoring of annual training requirements.	7/11/26
S 670	44:70:07:07 Medication Administration A registered nurse shall provide medication administration training pursuant to § 20:48:04.01 to any unlicensed assistive personnel employed by the facility who will be administering medications. Unlicensed assistive personnel shall receive initial and ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, interview, job description review, and policy review, the provider failed to ensure that one of three sampled registered medication aides (RMA) (G) received ongoing annual training for the administration of medications. Findings include: 1. RMA G was hired as an RMA on 11/2/24. He had completed his initial training and was placed on the medication aide registry on 12/16/24. There was no documentation in his personnel file that he had completed ongoing annual training related to the administration of medications. 2. Interview on 6/4/26 at 10:30 a.m. with co-owner/administrator in training A and co-owner/registered nurse (RN) /administrator B revealed they were not aware that it was a requirement that the RN conducted annual education and training for the medication aides and acknowledged that was not been completed with the medication aides employed at the facility.	S 670		

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S 670	Continued From page 44 3. Review of the 2024 Medication Aide job description revealed they were to complete "ongoing resident-specific training for medication administration, and annual training in all aspects of medication administration at the facility." 4. Review of the undated Registered Nurse - Senior Care Nurse job description revealed, "The RN will provide necessary ongoing training of such staff and determine that they are competent prior to assigning them duties." 5. Review of the 2024 Medication Aide Requirements policy revealed the an education qualification stating that he/she would complete "ongoing resident specific training for medication administration and annual training in all aspects of medication administration at the facility"	S 670		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing	S 685		

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S 685	Continued From page 45 self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and care record review, the facility failed to ensure one of one sampled resident (4) who self-administered his medications was evaluated quarterly to ensure he was able to administer his medications safely. Findings include: 1. Interview on 6/2/26 at 10:00 a.m. and again on 6/4/26 at 10:30 a.m.. with co-owner/administrator in training (AIT) A revealed that resident 4 was able to administer his own medications and kept them in a locked box in his room. 2. Review of resident 4's care record revealed that he admitted to the facility on 3/21/24. His diagnoses included type II diabetes mellitus (a condition in with disruptions in how the body regulates blood sugar), chronic kidney disease (a condition where the kidneys cannot filter properly), and high blood pressure. His mini-mental status evaluation completed on 3/14/25 revealed that he scored 30 out of 30 points, which indicated his cognition was intact. His self-administration of medication assessment was completed on 9/5/24 and 3/15/25. There was no documentation that an assessment was completed on or around December 2024, June 2025, September 2025, December 2025, or March 2026. The 9/5/24 and 3/15/25 assessments identified insulin and blood glucose monitoring as the items that could be self-administered. The assessments did not	S 685	All residents who self-administer medications have been reviewed to ensure current physician orders and required assessments are in place. The RN will complete and document self-administration assessments at least every three months and with any change in condition. The Administrator/designee will audit resident records quarterly to verify physician orders, assessments, and documentation are current. Any identified concerns will be corrected immediately. No policies changed or revised.	07/11/26

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S 685	Continued From page 46 address his oral medications. Resident 4's June 2026 medication administrator record revealed he was also self-administering six oral medications. These medications included amlodipine (a medication to lower blood pressure)10 milligrams (mg) daily, aspirin (blood thinner/stroke prevention) 81 mg daily, atorvastatin (a medication to lower cholesterol) 80 mg daily, lisinopril (a medication to lower blood pressure) 40 mg daily, vitamin D3 - one capsule every week, and acetaminophen (a medication to treat pain or fever) 325 -650 mg every six hours as needed. 3. Interview on 6/4/26 at 10:30 a.m. with co-owner/registered nurse (RN)/administrator B revealed the the resident's self-administration of medication assessments were to be completed quarterly and that was not done. She did not provide information as to why related to the exclusion of his oral medications were excluded from the self-administration of medication assessments. 4. A self-administration of medication policy was requested on 6/3/26 at 5:00 p.m. from co-owner/AIT A and was not received prior to the conclusion of the survey.	S 685		