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 |
|---|---|---|---|
| | 40563 | A. BUILDING: _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KELLY'S RETIREMENT II | 1522 EAST DAKOTA PIERRE, SD 57501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Compliance Statement<br><br>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 from 7/11/23 through 7/12/23. Kelly's Retirement II was found not in compliance with the following requirements: S200, S211, S296, S331, S450, S506, S701, and S775.<br><br>A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 7/11/23 through 7/12/23. Areas surveyed included nursing services, resident neglect, and resident rights. Kelly's Retirement II was found not in compliance with the following requirements: S701 and S866. | S 000 | | |
| S 200 | 44:70:03:01 General fire safety<br><br>Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition. An automatic sprinkler system is not required in existing facility unless significant renovations or remodeling occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling occurs.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, and record review, the facility failed to maintain an operational fire alarm system. | S 200 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Engel — TITLE: Administrator — (X6) DATE: 09/07/2023

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| S 200 | Continued From page 1<br><br>Findings include:<br><br>1. On 7/11/23 at 1:00 p.m., record review of reporting from the maintenance contractor revealed the fire alarm system could not be tested on 5/30/23 because the devices in the common area of the building were not reporting to the panel. It was also reported the batteries were older than allowed (date noted on the batteries as February 2011), but still functioning. The manual pull stations were functional during the maintenance review.<br><br>2. On 7/11/23 at 1:15 p.m. a fire drill was attempted with business office manager B. To initiate the drill, a manual pull station was pulled, and there was no system activation. A second manual pull station was pulled, and again there was no system activation.<br><br>Interview with the business office manager B on 7/11/23 at 1:20 p.m. revealed she had known the smoke detectors in the common area were not functioning, but she was unaware that the pull stations were not working. She asked the surveyor to advise one of the owners.<br><br>Failure to test the fire alarm system and to maintain an operational fire alarm system as required increases the risk of death or injury due to fire.<br><br>The deficiency affected two of numerous requirements for the fire alarm system. | S 200 | S 200<br><br>Contractor has now completed the replacement and installation of a new upgraded fire alarm system to include: Fire panel, batteries, pull stations and smoke detectors. The system has been tested and is fully operational.<br><br>The Administrator educated the maintenance person to do monthly functional testing each time the monthly fire drills are conducted and report to the administrator the results.<br><br>The results of the functionality and fire drills will be presented to the quarterly QA meeting. | 09/15/2023 |
| S 211 | 44:70:03:02.01(2) Staffing exceptions<br><br>(2) For each facility with 11 to 16 beds, inclusive, at least one staff person who is awake shall be | S 211 | | |

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| S 211 | Continued From page 2<br>on duty if:<br>(a) The facility fire alarm promptly alerts staff;<br>(b) A staff call system is available; and<br>(c) The residents have an evacuation score which shows them capable of prompt evacuation of three minutes or less as defined in §3.3.76, evacuation capability, of NFPA 101 Life Safety Code, 2012 edition.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review and interview, the provider failed to ensure staff were able to initiate a prompt evacuation in compliance with the Life Safety Code. Findings include:<br><br>1. Record review on 7/11/23 at 1:00 p.m. revealed there was documentation of fire drills from November 2022 through June 2023. The fire drill documentation for November 2022, December 2022, and January 2023 showed prompt evacuation, with evacuation times for all three months being two minutes fifty-one seconds. Each month following those drills had times varying from three minutes five seconds to three minutes fifteen seconds. The definition of prompt evacuation was evacuation in less than three minutes.<br><br>Interview with business office manager B at the time of the record review confirmed those findings. She was unaware that the required evacuation time was three minutes.<br><br>The deficiency had the potential to affect 100% of the occupants of the building. | S 211 | S 211<br><br>Administrator or designee educated all staff and maintenance that fire drills are to be completed monthly and that an evacuation time of 3 minutes or less must be attained at each drill session. If failure is achieved, then retraining of all staff must happen and a new drill conducted until the 3 minute threshold is achieved. If the 3 minute threshold is not met, the maintenance person will re-educate the staff on duty and perform testing until the 3 minute threshold is met.<br><br>Administrator will monitor and audit all fire drills and documentation monthly for 3 months to ensure compliance and report audit findings to the QA committee for one quarter. | 09/15/2023 |

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| S 296 | Continued From page 3<br>S 296 44:70:04:04 Personnel training<br><br>Ongoing education programs must cover the required subjects annually. These programs must be completed within 30 days of hire for all healthcare employees and must include the following subjects:<br>(1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff;<br>(2) Emergency procedures and preparedness;<br>(3) Infection control and prevention;<br>(4) Accident prevention and safety procedures;<br>(5) Resident rights;<br>(6) Confidentiality of resident information;<br>(7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;<br>(8) Nutritional risks and hydration needs of residents;<br>(9) Abuse, neglect, and misappropriation of resident property and funds;<br>(10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility, and;<br>(11) Any additional healthcare employee education necessary based on the individualized resident care needs provided by the healthcare employees to the residents who are accepted and retained in the facility.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on review of employee training files, | S 296 | S 296<br>S 296<br>Unable to change prior non compliance.<br>Employee D- File complete<br>Employee G- File complete<br>Employee E- File complete<br><br>All current employee files and annual training is complete.<br><br>Administrator has educated the BOM and nurse that Employee records will be completed and include New Hire training within 30 days of hire and annual training records.<br><br>New hire and annual training topics will include:<br><br>- Fire<br>- Emergency procedures and preparedness<br>- Infection control and prevention<br>- Accident prevention and safety<br>- Resident Rights<br>- Confidentially of resident information<br>- Incidents and disease-mandatory reporting<br>- Nutritional risks and hydration<br>- Abuse neglect<br>- Problem solving and communication<br>- Additional health care education deemed necessary by administration, nurse or designee<br><br>Audits of all employee files and training records will be monitored by the Administrator or designee on a monthly basis for 4 months. The results of the audit will be presented to the quarterly QA committee. Audits will continue until compliance is maintained for 2 quarters. | 09/15/2023 |

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interview, and employee orientation/checklist review, the provider failed to provide a formal orientation program that included required education topics for three of five sampled employees (D, E, and G) within 30 days of their date of hire. Findings include:

1. Review of employee D's training and orientation records revealed the following:
*She was hired on 4/17/23.
*There was no documentation she had completed training on the following required subjects:
-Fire drills.
-Emergency preparedness.
-Accident prevention and safety procedures.
-Resident rights.
-Confidentiality.
-Incidents and diseases subjected to mandatory reporting.
-Nutrition risks and hydration.
-Problem-solving and communication techniques related to residents with cognitive impairment or challenging behaviors.

2. Review of employee E's training and orientation records revealed the following:
*She was hired on 1/14/23.
*There was no documentation she had completed training on the following required subjects:
-Fire drills.
-Emergency preparedness.
-Infection prevention and control.
-Accident prevention and safety procedures.
-Resident rights.
-Incidents and diseases subjected to mandatory reporting.
-Nutrition risks and hydration.
-Abuse, neglect, and misappropriation of resident funds and property.
-Problem solving and communication techniques

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| S 296 | Continued From page 5 | S 296 | | |

related to residents with cognitive impairment or challenging behaviors.
-Education based on the resident's care needs.
The facility was licensed for the following:
--Cognitively impaired residents.
--Physically impaired residents.
--Residents who were dependent on supplemental oxygen.

Interview on 7/12/23 at 8:55 a.m. with employee E about the training she had received revealed:
*She stated that she had received no training from the provider on the topics of dementia, caring for people with dementia, or how to handle resident behaviors.
*She had previously been a certified nursing assistant at a different facility, and she drew from that experience to help with her current duties.

3. Review of employee G's training and orientation records revealed:
*She was hired on 4/18/23.
*There was no documentation she had completed training on any of the following required subjects:
-Fire drills.
-Emergency preparedness.
-Infection prevention and control.
-Accident prevention and safety procedures.
-Resident rights.
-Confidentiality.
-Incidents and diseases subjected to mandatory reporting.
-Nutrition risks and hydration.
-Abuse, neglect, and misappropriation of resident funds and property.
-Problem-solving and communication techniques related to residents with cognitive impairment or challenging behaviors.
-Education based on the resident's care needs.
The facility was licensed for the following:

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--Cognitively impaired residents.
--Physically impaired residents.
--Residents who were dependent on supplemental oxygen.

4. Interview on 7/12/23 at 12:10 p.m. with licensed practical nurse C about the above employee's training records revealed:
*They had no copy of employee G's training records.
*She guessed that employee G might have taken her training records home.
*She had no additional comments about employee D's missing training records.
*Employee E had the same last name as a different employee.
-She stated that employee E's training records might have been placed in a different employee's file. She was unable to locate her complete training records.

5. Review of the provider's "Employee Orientation/Checklist" revealed:
*The checklist included the following items:
-"Resident Rights/HIPAA [Health Insurance Portability and Accountability Act]/Privacy"
-"Handy Hygiene"
-"Fire Safety/Emergency Procedures"
-"Resident Abuse Training"
-"Infection Control"
-"Oxygen Training"
-"Alzheimer's Disease/Aging Training"
-"Elopement Training"
*The rest of the packet included descriptions of the following:
-"Fire Prevention & Response"
-"Emergency Procedures and Preparedness"
-"Infection Control and Prevention"
-"Accident Prevention and Safety"
-"Residents Rights"

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| S 296 | Continued From page 7<br>-"Confidentiality and HIPAA"<br>-"Mandatory Reporting"<br>-"Dietary In-Service Training"<br>-"Hydration"<br>-"Resident Abuse/Employee Abuse"<br>-"Problem Solving and Communication Techniques"<br>-"Care of residents with unique needs" | S 296 | | |
| S 331 | 44:70:04:10 Tuberculin screening requirements<br><br>Tuberculin screening requirements for healthcare employees or residents are as follows:<br>(1) Each healthcare employee or resident shall receive an annual individual TB risk assessment that is documented and the two-step method of tuberculin skin or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12-month period prior to the date of admission or employment are considered a two-step. A TB blood assay test completed within a 12-month period prior to the date of admission or employment is considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation of the last skin or blood assay TB testing completed within the prior 12 months. Skin testing or a TB blood assay test is not necessary if documentation is provided of a previous positive reaction to either test. Any healthcare employee or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or | S 331 | S 331<br><br>Unable to change prior non-compliance<br><br>Resident 2 - Unable to change prior non-compliance<br>Resident 5 - Resident is no longer in facility<br>Resident 1 - Unable to change prior non-compliance<br><br>Employee E- Unable to change prior non-compliance<br>Employee I- Unable to change prior non-compliance<br><br>The Administrator has educated the nurse and BOM to the requirements of TB screening to ensure that all TB testing on New Hires and residents will be performed within 14 days of hire and/or admission by the nurse or at the local Urgent Care clinic and proper documentation will be kept within employee and resident files.<br><br>Audit of the employee and resident files and TB Testing will be monitored by the Administrator or designee on a monthly basis for 4 months. The results of the audit will be presented to the quarterly QA committee. Audits will continue until compliance is maintained for 2 quarters. | 09/15/2023 |

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| S 331 | Continued From page 8<br>absence of the active disease.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review, interview, and policy review, the provider failed to ensure:<br>*Three of five sampled residents (1, 2, and 5) had their two-step tuberculin (TB) screening completed within fourteen days of admission.<br>*Two of five recently hired sampled employees (E and I) had their two-step TB screening completed within fourteen days of being hired.<br>Findings include:<br><br>1. Review of resident 2's care record revealed:<br>*She was admitted on 5/10/23.<br>*Her first step TB was dated 5/30/23.<br>*Her second step TB was dated 6/6/23.<br>*Her TB screen had been completed on 6/8/23, which was 29 days after she was admitted.<br><br>2. Review of resident 5's closed care record revealed:<br>*She was admitted on 2/25/23.<br>*She discharged on 4/8/23, indicating she had stayed at the facility for 42 days.<br>*There was no documentation that any type of TB screening had been completed.<br><br>3. Review of resident 1's care record revealed:<br>*She was admitted on 9/8/22.<br>*There was no documentation that any type of TB screening had been completed.<br><br>4. Review of employee E's personnel file revealed:<br>*She was hired on 1/14/23.<br>*Her TB screen was completed on 3/20/23, which was 65 days after she was hired. | S 331 | | |

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5. Review of employee I's personnel file revealed:
*She was re-hired on 11/5/21.
*Her TB screen was completed on 8/12/22, which was 280 days after she was re-hired.

6. Interview on 7/12/23 at 12:10 p.m. with licensed practical nurse C about the TB screening for residents and staff revealed:
*She was aware there were several employees and residents who had not received their TB screening in a timely manner.
*Since she was there on Tuesdays and Wednesdays only, she was unable to perform the two-step Mantoux TB screen for employees and residents.
*She stated that she directed new employees and residents to obtain a TB screen at a local clinic, and then asked them to provide the supporting documentation.

7. Interview on 7/12/23 at 2:00 p.m. with business office manager B about the TB screening for residents and staff revealed:
*The provider was not performing the TB screenings.
*During resident 5's admission process, her family had been asked to obtain a TB screening at the local clinic.
*She was aware some residents had not received their TB screening in a timely manner.
*She could not think of a way to maintain compliance with the 14-day requirement to ensure the TB screening was completed.

8. Review of the provider's 2019 "Required TB Testing and Recommended Vaccinations" policy revealed:
*"Each new resident or new staff person must have a two-step Mantoux TB test within 14 days

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| S 331 | Continued From page 10<br>of admission or employment."<br>*"The Registered Nurse or Manager will set-up and monitor the completion of any required TB testing for new employees and residents."<br>*"A community nurse will work with the Manager to assure all required testing is completed." | S 331 | | |
| S 450 | 44:70:06:01 Dietetic services<br><br>The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of §44:70:02:06.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview, observation, job description review, and policy review, the provider failed to maintain a safe and sanitary environment for food service related to the following:<br>*Kitchen cleanliness and sanitation related to:<br>-Stainless-steel table with a substance seared onto the top and dirty shelf beneath.<br>-Exhaust fan with no filter.<br>-Oven with burnt, brown substances.<br>-Stove/oven hood with soot.<br>-Microwave that was dirty and greasy.<br>-Fridges that contained:<br>--Dust particles on top.<br>--Thermometers that displayed temperatures above those needed for cold food storage.<br>--Food and juice spills on the inside.<br>--Leftover food not labeled or dated.<br>--Raw meat thawing over ready-to-eat food | S 450 | | |

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| S 450 | Continued From page 11<br>increasing the risk for cross-contamination.<br>-Dry storage room that contained:<br>--An opened jar of jelly that should have been refrigerated.<br>--Scoops had been left in the flour and sugar bins increasing the risk for cross-contamination.<br>*Monitoring of food temperatures prior to serving the residents' meals.<br>*Monitoring of dishwasher temperatures to ensure sanitation.<br>Findings include:<br><br>1. Interview on 7/11/23 at 8:20 a.m. with personal care assistant (PCA)/unlicensed medication aide (UMA) E revealed she was concerned regarding how the hamburger had been stored in the fridge as it had been left to thaw on a shelf over ready-to-eat food.<br><br>Observations on 7/11/23 at 8:25 a.m. in the kitchen revealed:<br>*The stainless-steel table in front of the serving window had a burnt brown plastic-like substance seared onto the top that was able to have been removed by a fingernail with pressure.<br>*The open shelf on the table, below the tabletop was not clean with food particles on it.<br>*The household vent over the two household stove/ovens had no filter, leaving the fan blades exposed.<br>*The one working oven appeared dirty with burnt substances on the bottom of the oven and a brown substance on the oven racks and on the inside of the oven door.<br>*The hood over the stove/oven had soot on it that had come off with a facial tissue and foam hand soap.<br>*There were two fridge/freezers in the kitchen, both had dust and food crumbs on top of the fridge. | S 450 | S 450<br>Unable to change prior non-compliance<br><br>BOM has completed certification of the ServSafe dietary manager program and is responsible for the overall dietetic services.<br><br>All areas defined in the deficiency of this tag have been cleaned and sanitized. All staff have been educated in the cleaning procedures of the kitchen. BOM or designee will educate all staff currently, annually and within 30 days of new hire on the following:<br><br>Food storage procedures<br>Food container labeling and date process<br>Proper thaw methods<br>Proper placement of food in refrigeration<br>Scoops in storage bins are to be stored in a clean and sanitary way between uses<br>Proper cleaning procedures of using the food temperature probe and documentation of food temps prior to serving.<br><br>Proper cleaning procedures of all food areas/ equipment and a checklist developed to be used daily.<br><br>Proper monitoring, documenting and reporting of fridge/freezer/dishwasher temps.<br><br>The employee files, training records, documentation of cleaning checklists, fridge/freezer temps and food serving temps and observations will be randomly monitored with a sample of each 2x per week by the BOM or designee on a weekly basis for 4 weeks then monthly for 4 months. The results of the audit will be presented to the quarterly QA committee. Audits will continue until compliance is maintained for 2 quarters. | 09/15/2023 |

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| S 450 | Continued From page 12<br>*The fridge on the right side had a "Taylor" brand name digital thermometer on the inside of the fridge that read 45 degrees Fahrenheit (F), which should have been 41 degrees F or below, and contained the following:<br>-A steel pan with lid, approximately 11 inches (") by 17" in size, with left over ham inside that was not labeled or dated.<br>-On the middle shelf was a large oven baking sheet with a ten-pound tube of raw ground beef, partially frozen, with the tube overlapping the front edge of the baking sheet by two inches.<br>-Directly underneath that baking sheet was an 11" by 17" container of ready-to-eat cookies with no label or date.<br>*Between the fridges was a shelving unit with a microwave oven with a soiled door, the inside was dirty with food substances on the walls and inside of door, and the bottom glass plate was covered with a greasy substance that had contributed to the risk of cross-contamination.<br>*The fridge on the left side had food and juice spills on the inside shelves and sides.<br>*The dry storage room open to the kitchen revealed the following:<br>-A 30-ounce container of grape jelly on a shelf:<br>--The container had been opened with approximately half of the contents remaining.<br>--The label stated, "Refrigerate after opening."<br>-An approximately ten-gallon plastic "Sterilite" container of white flour with a metal measuring cup in the flour, the lid was labeled with the date "8-29-22."<br>-An approximately five-gallon plastic "Sterilite" container of white sugar with a metal one-fourth measuring cup in the sugar, no label or date was found on the lid.<br><br>2. Observation of the provider's fridge and interview on 7/11/23 at 8:55 a.m. with PCA/UMA | S 450 | | |

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D revealed the ready-to-eat cookies were "no-bake" cookies that had been made on 7/10/23 and they should have been labeled and dated.

3. Interview on 7/11/23 at 9:25 a.m. with licensed practical nurse (LPN) C revealed:
*The provider's full-time cook, who had been in charge of the dietary services, had stopped coming to work about three weeks ago and she was not sure as to why.
*Business office manager (BOM) B had been in charge of the dietary services since the full-time cook had quit working and she was working on her ServSafe certification.

4. Interview on 7/11/23 at 10:05 a.m. with BOM B revealed:
*She confirmed the provider's "cook quit about three weeks ago."
*She confirmed she was in charge of the dietary services and was in the process of getting her ServSafe certification.

5. Observation and interview on 7/11/23 at 11:50 a.m. in the kitchen with PCA/UMA D revealed:
*The right fridge's "Taylor" brand name digital thermometer read 44 degrees Fahrenheit.
*After a discussion regarding the appropriate temperature range for refrigeration and monitoring of the fridge temperatures, she:
-Was not sure what temperature was appropriate.
-Stated "they had a cook - he wrote them down" referring to the fridge temperatures, but it had been a couple of weeks since he had left and they had not been recording temperatures since then.
-Stated there was a form that BOM B had told them about to record temperatures, but she was not sure where it was.

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| S 450 | Continued From page 14<br>*She agreed the hamburger should not have been placed above the cookies when thawing.<br>*She had moved the hamburger to the bottom shelf of the fridge, placing the cookies on an upper shelf.<br><br>Observation on 7/11/23 from 12:00 noon through 12:15 p.m. of the noon meal service revealed:<br>*PCA/UMA D:<br>-Removed two casseroles of "Ziti Alfredo" from the oven and took a thermometer probe, removed its cover, and without sanitizing the probe, inserted the probe into one of the casseroles.<br>-After reading the temperature of the first casserole, she used a paper towel to wipe off the probe and then finished wiping the probe with a cloth hand towel that was on the kitchen counter before she had inserted the probe into the second casserole.<br>-She had not recorded the temperatures of either casserole and had not cleaned or disinfected the probe correctly.<br>*PCA F:<br>*Removed a bowl of green beans from the microwave oven and served the green beans to the residents without ensuring the green beans were at an adequate temperature.<br><br>Interview on 7/11/23 at 12:18 p.m. with PCA F revealed she:<br>*Agreed she had taken the green beans out of the microwave and served them to the residents without assuring they had been at an appropriate temperature.<br>*Stated "They were warm."<br>*Agreed the microwave was not clean on the outside and inside and that increased the risk of cross-contamination.<br>*Was not sure who was responsible to have cleaned the microwave. | S 450 | | |

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Interview on 7/11/23 at 12:20 p.m. with PCA/UMA D revealed she:
*Agreed she had not sanitized the thermometer probe before she had inserted it into the first casserole.
*Agreed she had used a paper towel and cloth hand towel to clean the thermometer probe before she had inserted it into the second casserole.
*Questioned the surveyor if that was appropriate.
*Agreed she should have sanitized the thermometer probe before inserting it into the casseroles to ensure the food had not been potentially contaminated.

Observation of the provider's kitchen and interview on 7/11/23 at 12:30 p.m. with BOM B revealed:
*The fridge on the right side's "Taylor" brand name digital thermometer that was located inside the fridge read 47 degrees Fahrenheit.
*The fridge on the left side's "Taylor" brand name digital thermometer that was located inside the fridge read 42 degrees Fahrenheit.
*She agreed with the above temperature readings that those readings were above what was appropriate but was not sure what the appropriate temperature range was for refrigerators, asking "32 to 35?" degrees Fahrenheit.
*When asked about cleaning of the fridge she stated "it's been a while."
*She agreed:
-The two fridge/freezers in the kitchen needed to have been cleaned.
-The 11" by 17" steel pan and lid with the left over ham inside from yesterday, 7/10/23, should have been labeled and dated.
-The ten-pound tube of raw ground beef, partially frozen, should not have been placed over a

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container of ready-to-eat cookies.
-The microwave needed to have been cleaned both on the inside and outside.
-The thermometer probes should have been sanitized before inserting them into food items.
-The stainless-steel table in front of the serving window needed a deep cleaning to remove the burnt brown plastic-like substance seared onto the top.
-The open shelf underneath the stainless steel tabletop needed to have been cleaned.
-The opened grape jelly container in the dry storage area should have been refrigerated after it was opened according to the manufacturer's instructions.
*She stated the staff working the 12-hour night shift "typically does the deep cleaning" in the kitchen.
*She stated as manager of the kitchen "I guess I'm in charge of the kitchen" and should have made sure the kitchen cleaning had been done.

Observation of the provider's kitchen and interview on 7/12/23 at 8:53 a.m. with BOM B revealed:
*She had placed a round NSF (National Sanitation Foundation) thermometer in each of the fridges yesterday afternoon.
*The fridge on the right side contained a round NSF thermometer that read 33 degrees Fahrenheit. *The "Taylor" brand name digital thermometer in the same fridge had read 38 degrees Fahrenheit.
*The fridge on the left side contained a round NSF thermometer that read 40 degrees Fahrenheit. *She had moved the "Taylor" brand name digital thermometer to the freezer above that fridge as it had no thermometer.
*She agreed the staff should have been monitoring and recording the fridge temperatures

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to ensure the temperatures were adequate.
*She agreed the green beans that were served with yesterday's lunch should have had the temperature checked prior to serving.
*Her expectation of the staff was to have taken and recorded the temperatures of the food items prior to serving the food to the residents.
*The dishwasher in the kitchen was a mechanical dishwasher that was santized by heat.
-The staff was not currently recording the temperatures of the dishwasher's wash and rinse cycles to ensure sanitation.
-She stated "we can start" taking the dishwasher temperatures.
-She agreed with the importance of ensuring the sanitation process of the dishwasher.
*The ceiling vent in the dry storage room was covered with lint that was easily removed and she agreed the vent needed to have been cleaned.
*The filter that was to have covered the exhaust fan over the stoves had been laying on the floor by the handwashing sink, which had left the fan blades of the exhaust fan exposed and she agreed the filter needed to have been cleaned and replaced to cover the fan blades.
-She stated the reason for that was the maintenance staff person had only reported to the facility once every two to three weeks as he was responsible for other facility locations.
-When asked if there was a cleaning list for the staff she had replied "we used to" but currently there was no cleaning list for the kitchen staff to follow.

Review of the provider's three-ring binder on 7/11/23 that had been kept in the kitchen revealed:
*The "Weekly Menu" sheet for Monday, 7/10/23 through Sunday, 7/16/23 with the "LUNCH" menu for Monday, 7/10/23 which had "Ham"

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| S 450 | Continued From page 18<br>handwritten in.<br>*Several "Temperature Log" forms each with a different day from 7/1/23 through 7/11/23.<br>-The form for each day contained the menu items for each meal along with a space to record the temperatures of each item.<br>-The bottom of the form had a space to record:<br>--"Freezer Temp"<br>--"Cooler Temp"<br>--"Dishwasher Temp"<br>-The form's last printed line stated "File this copy."<br>*None of the temperature logs reviewed had any temperatures documented on the forms.<br><br>Review of the provider's 4/29/19 policy on "Dietary Services Policies" revealed:<br>*"All hot foods must be kept at 140 degrees or above at all times during serving and must be refrigerated immediately after serving."<br>*"Leftovers must be covered, marked with date and contents, and used within three days of preparation."<br>*"The Kitchen Manager is responsible for ensuring all food is properly handled."<br>*"The following guidelines shall be followed on a daily basis."<br>-"FOODS must be properly refrigerated and maintained at 41 degrees or lower..."<br>-"ALL REFRIGERATORS must be provided with thermometers and maintained at 41 degrees or lower. All freezers at 0 degrees or lower."<br>-"A DISH WASHING MACHINE, if used, must maintain a rinse temperature of at least 170 degrees if it is a hot water sanitizing unit..."<br>-"ALL WORK TABLE TOPS & FOOD PREPARATION EQUIPMENT, GRINDERS, SLICERS, AND SO FORTH are to be cleaned and sanitized after each use or during periods of reduced activity." | S 450 | | |

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| S 450 | Continued From page 19<br><br>-"ALL FOODS NOT stored in the original containers must be labeled as to its contents."<br>*The policy did not address the following:<br>-Appropriate thawing of meat and how it was to be stored.<br>-Storage of scoops in containers.<br>-Oversight of dietary services. | S 450 | | |
| S 506 | 44:70:06:17 Required dietary inservice training<br><br>The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. The training shall be provided to any dietary or food-handling employee within 30 days of hire and annually.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on employee training record review, interview, and orientation checklist review, the provider failed to ensure the required dietary inservice training (food safety, handwashing, food handling/preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements) had been completed for three of five recently hired staff (D, E, and G) within 30 days of their date of hire. Findings include:<br><br>1. Review of training records for employees D, E, | S 506 | S 506<br><br>Unable to change prior non compliance<br><br>The BOM or designee will train all staff. to include Employees D, E & G, in the following topics currently and within 30 days of hire and annually<br><br>- Food Safety<br>- Handwashing<br>- Food handling and preparation techniques<br>- Food borne illness<br>- Serving and distribution procedures<br>- Leftovers food handling<br>- Time and temperature controls<br>- Nutrition and hydration<br>- Sanitation requirements<br>Training records will be kept in the employee file.<br><br>Audits of the employee files and training records will be monitored by the Administrator or designee on a monthly basis for 4 months. The results of the audit will be presented to the quarterly QA committee. Audits will continue until compliance is maintained for 2 quarters. | 09/15/2023 |

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and G revealed the following:
*Employee D was hired on 4/17/23.
-There was documentation that she had been educated on sanitation requirements, but none of the other required dietary topics had been documented.
*Employee E was hired on 1/14/23.
*Employee G was hired on 4/18/23.
-There was no documentation that they had been educated on the above required dietary inservice topics.

2. Interview on 7/12/23 at 8:55 a.m. with employee E about her training and orientation revealed:
*All of the employees would help out in the kitchen because the cook had stopped coming to work.
*She worked the night shift and would make snacks and sandwiches for the residents.
*She stated she had not received any training regarding the required dietary inservice topics.

3. Interview on 7/12/23 at 12:10 p.m. with licensed practical nurse C about the above employee's training records revealed:
*They had no copy of employee G's training records.
*She guessed that employee G might have taken her training records home.
*She had no additional comments about employee D's missing training records.
*Employee E had the same last name as a different employee.
-She stated that employee E's training records might have been placed in a different employee's file. She was unable to locate her complete training records.

4. Review of the provider's "Employee

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| S 506 | Continued From page 21<br>Orientation/Checklist" revealed:<br>*There was a section of the packet titled, "Dietary In-Service Training."<br>*The description read, "Basic food safety, handwashing dishes, sanitary food handling and preparation techniques, food borne illnesses, serving and distributing procedures, leftover food handling, time and temperature controls for food preparation and service, and sanitation requirements." | S 506 | | |
| S 701 | 44:70:08:01 Record service<br><br>The resident care records shall include the following:<br>(1) Admission and discharge data including disposition of unused medications;<br>(2) Report of the physician's, physician assistant's, or nurse practitioner 's admission physical evaluation for resident;<br>(3) Physician, physician assistant, or nurse practitioner orders;<br>(4) Medication entries;<br>(5) Observations by personnel, resident's physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and<br>(6) Documentation that assures the individual needs of residents are identified and addressed.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on interview, record review, and observation, the provider failed to ensure three of five sampled residents (1, 2, and 4) had documentation to support their individual care needs had been identified and addressed to provide the necessary care. Findings include: | S 701 | | |

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| S 701 | Continued From page 22<br><br>1. Interview on 7/11/23 at 10:34 a.m. with resident 4 about his insulin revealed:<br>*He was to self-administer 28 units of insulin daily at 7:00 p.m.<br>*There was one night "within the last month" where no one brought his insulin for him to self-administer.<br>*He had to remind the night staff person to deliver his insulin to his room.<br><br>Review of resident 4's care record and medication administration record (MAR) for May 2023 and June 2023 revealed the following:<br>*His most recent Mini-Mental State Examination score from 1/5/23 was 30 out of 30 possible points, indicating normal cognition.<br>*There was no documentation that his insulin had been provided to him by staff for self-administration on the following dates:<br>-5/2/23, 5/7/23, 5/12/23, 5/20/23, 5/21/23, 5/23/23, 6/2/23, 6/4/23, 6/8/23, and 6/9/23.<br><br>Interview on 7/12/23 at 9:08 a.m. with licensed practical nurse (LPN) C about the missing insulin documentation revealed:<br>*Resident 4 always received his insulin daily.<br>*She agreed the missing insulin documentation appeared as if the resident had not received his insulin.<br>*Staff might have forgotten to document that he had received his insulin.<br><br>2. Observation and interview on 7/11/23 at 11:20 a.m. with resident 2 revealed she:<br>*Was wearing compression stockings on her legs.<br>*Required staff assistance with her compression stockings to:<br>-Put them on in the morning. | S 701 | S701<br>Unable to change prior non compliance<br><br>Resident care records for residents 1,2 and 4 have been updated as well as all other resident care records by the nurse.<br><br>Administrator or designee has educated the nurse and all staff on the following:<br><br>Proper insulin self-administration and documentation for all UMA's and the nurse.<br>Proper compression stocking care and documentation<br>Proper skin care/observations and documentation<br>Proper documentation in PCC in the POC program of care given and observations noted to include behavioral issues and interventions.<br>Resident health care records and charting will be completed in Point Click Care computer program by all staff and the nurse and maintained according to industry standards.<br><br>The Nurse or designee will randomly observe the documentation and administration of insulin self-administration, compression stocking care. behaviors and individual needs on 2 resident per week for 4 weeks then monthly for 4 months.<br><br>Audits of the care records will be monitored by the BOM or designee on a monthly basis for 4 months. The results of the audits will be presented to the quarterly QA committee. Audits will continue until compliance is maintained for 2 quarters. | 09/15/2023 |

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-Take them off at bedtime.
*Took a shower weekly with staff assistance.

Review of resident 2's care record revealed:
*She was admitted on 5/10/23.
*Her 5/10/23 mini mental score was 26 out of 30 that indicated she was cognitively intact.
*Her progress notes included:
-A 5/10/23 "Move-In Note"
-A 5/16/23 "Health Status Note"
-No progress notes were entered for an eight week period from 5/17/23 to 7/12/23.
*Her 5/10/23 service plan included:
-A focus on bathing that identified she required assistance for bathing/showering.
-There was no documentation of her need to wear compression stockings daily or her requiring staff assistance putting them on or taking them off.
*Review of her point of care (POC) documentation for the past thirty days on 7/11/23 at 4:35 p.m. revealed:
-The caregiver task to "Ensure Compression Socks are on in the morning and off at HS [at bedtime]" asked the staff to document "Task completed?" with no responses and "No Data Found."
-The caregiver task regarding "BATHING/SHOWERING" asked the staff to document:
--"How much assistance was provided?"
--"Skin Observation"
--"BATHING: SELF PERFORMANCE"
--"BATHING: SUPPORT PROVIDED"
--With no responses and "No Data Found."

3. Interview on 7/11/23 at 3:30 p.m. regarding charting progress notes with LPN C revealed

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| S 701 | Continued From page 24<br>there were no specific guidelines on how often to enter a progress note in a resident's care record. She stated she usually had entered a progress note if any resident significant change occurred, after an evaluation was completed, and after a physician's visit.<br><br>Interview on 7/12/23 at 8:15 a.m. with administrator A revealed:<br>*He was a co-owner of this facility and two other facilities.<br>*He had usually come to the facility twice a month and designated business office manager B to have been his representative in his absence.<br>*His expectation was for a progress note to have been entered into each resident's care record weekly.<br>*The weekly progress note would reflect any change in condition, medication changes, family issues, etc.<br>*In discussing the absence of progress notes for those months in residents 2 and 4's care record he was concerned and stated, "that's a deficiency."<br><br>4. Observations, interviews, and record review related to resident 1 during the survey from 7/11/23 through 7/12/23 revealed her care needs related to behavioral health interventions, and an assessment of her needs were not properly documented or completed.<br>Refer to S866. | S 701 | | |
| S 775 | 44:70:09:02 Facility to inform resident of rights<br><br>Prior to or at the time of admission, a facility shall inform the resident, both orally and in writing, of the resident's rights and of the rules governing the resident's conduct and responsibilities while | S 775 | | |

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| S 775 | Continued From page 25<br>living in the facility. The resident shall acknowledge in writing that the resident received the information. During the resident's stay the facility shall notify the resident, both orally and in writing, of any changes to the original information.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review, interview, and policy review, the provider failed to document that newly admitted residents had been informed of their resident rights as a resident living in an assisted living facility for three of five sampled residents (1, 2, and 5). Findings include:<br><br>1. Review of resident 2's care record revealed:<br>*She was admitted on 5/10/23.<br>*Her admission agreement was signed and dated on 5/11/23.<br>*There was no documentation found indicating the resident or her representative had reviewed or signed an acknowledgement of the receipt of the resident's rights.<br><br>Interview on 7/12/23 at 10:55 a.m. with administrator A about resident 2's missing documentation of the receipt of resident's rights revealed:<br>*He had gone through the admitting paperwork for resident 2 and could not find that document.<br>*He had called resident 2's daughter and had asked if they had the document with the admission paperwork but she stated she had no resident rights document.<br><br>2. Review of resident 1's care record revealed:<br>*She was admitted on 9/8/22.<br>*There was no documentation found indicating | S 775 | S775<br>Unable to change prior non compliance<br><br>All resident's have been provided a copy of the resident's rights and a signed acknowledgment has been obtained and placed in their file.<br><br>At the time of admission, the Administrator or designee will present a copy of the resident rights to the new resident and family. A signed acknowledgment will be obtained and placed in their file.<br><br>Audits of new residents admissions records will be monitored by the Administrator or designee on a monthly basis for 4 months. The results of the audit will be presented to the quarterly QA committee. Audits will continue until compliance is maintained for 2 quarters. | 09/15/2023 |

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| S 775 | Continued From page 26<br>the resident or her representative had reviewed or signed an acknowledgment of receipt of the resident's rights.<br><br>3. Review of resident 5's closed care record revealed:<br>*She was admitted on 2/25/23.<br>*She was discharged on 4/8/23.<br>*There was no documentation found indicating the resident or her representative had reviewed or signed an acknowledgment of receipt of the resident's rights.<br><br>Interview on 7/12/23 at 10:32 a.m. with administrator A about resident 5's missing documentation revealed:<br>*He went through the admitting paperwork, including resident rights, with resident 5 and her family.<br>*He could not locate the signed acknowledgement of the resident's rights.<br><br>4. Review of the provider's 2019 "Admissions/Discharge Criteria" revealed there was no reference of reviewing a resident's rights with a resident and/or their representative prior to their admission to the facility. | S 775 | | |
| S 866 | 44:70:09:14(1-3) Admission, transfer, and discharge policies<br><br>The policies and procedures must include the following provisions:<br>(1) The resident may not be transferred or discharged unless the resident's needs and safety cannot be met by the facility, the residents' health has improved sufficiently so the resident no longer needs the services provided by the facility, the safety or health of persons in the | S 866 | | |

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| S 866 | Continued From page 27<br>facility is endangered by the resident, the resident has failed to pay for allowable billed services as agreed to, or the facility ceases to operate;<br>The facility shall conduct an evaluation or assessment of each resident to determine if the facility is able to meet the needs of the resident. The determination must be discussed with the resident or designated representative and documented in accordance with §§44:70:01:05 and 44:70:05:03. If the facility is not able to meet the needs of the resident, discharge planning in accordance with §44:70:04:16 will be coordinated with the other facility, the resident, and family member or designated representative to an appropriate level of care to meet the resident's individualized needs.<br>(2) The facility shall notify the resident or designated representative and state ombudsman in writing at least 30 days before the transfer or discharge. If the resident's health requires immediate transfer or discharge the 30 days notices is not required. The written notice shall specify the reason, effective date, and the location to which the resident will be transferred or discharged; and<br>(3) The facility shall provide to the resident or designated representative a description of how the resident may appeal a decision by the facility to transfer or discharge the resident including the right to a fair hearing.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review, interview, observation, and policy review, the provider failed to conduct an evaluation of needs and consistently document resident behavioral health incidents for one of five sampled residents (1) to support their 30-day eviction notice. Findings include: | S 866 | S 866<br>Unable to change prior non compliance<br><br>The nurse has educated all staff on dementia care, techniques to use on aggressive behaviors and proper documentation of encounters.<br><br>The Administrator has educated the nurse and BOM on the proper documentation, family communication and assessments for significant change of health and/or behaviors and the proper discharge planning procedures.<br><br>The Administrator has educated the nurse and BOM to the monitoring and documentation of behaviors and changes weekly for resident 1 and any future residents.<br><br>Audits of resident 1's behaviors, assessments, communications with the family and documentation will be monitored by the Administrator or designee on a weekly basis for 4 weeks and an evaluation done as to whether resident 1 is qualified for assisted living services.<br><br>The results of the audit will be presented to the quarterly QA committee and a decision made as to the continued residency of resident 1 will be made at that time.<br><br>Audits of any residents in the discharge planning stage, assessments, communications with the family and documentation will be monitored by the Administrator or designee on a weekly basis for 4 weeks.<br><br>The results of the audit will be presented to the quarterly QA committee and a decision made as to the continued residency of those residents will be made at that time. | 09/15/2023 |

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1. Review of the 30-day eviction notice revealed:
*The title of the document read, "30-Day Written Discharge Notice."
*The notice was issued to resident 1.
*The issue date was 6/27/23.
*The effective date was 6/28/23.
*The body of the document read, "You are being requested to move within 30 days of receipt of this notice for the following reason(s):"
-"Your behavioral needs exceeds the level of services provided by the facility."
-"You have engaged in aggressive behavior or actions that have interfered with the rights, health or safety of residents or others, and/or you have exhibited behavior that poses a danger to self or others."
*The document was delivered to the following people:
-"1. [Name] - Daughter - [power of attorney] - Sent certified return receipt on 06/28/2023 and verbally in person on 06/23/2023."
-"2. [Resident 1] - Resident (Hand delivered on 06/28/2023."
*The "Discharge Plan" was as follows:
-"Discharge planning has been completed and the following facilities [have been] contacted and acknowledged the availability of beds. All requested information concerning moving to another facility has been sent to each for evaluation."
-Three nursing home facilities were listed.
*There was a statement at the bottom of the document which read:
-"If you disagree with this notice you may file a written appeal to the Administrator within 5 days of receipt of this notice.
-"If the Administrator cannot offer a suitable resolution, then an appeal can be made to the Governing Board within 5 days of the

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Administrator's resolution."
-"All notices and appeals must be in writing and either hand delivered with written receipt or sent [United States Postal Service] certified mail."

Review of resident 1's care record revealed:
*She was admitted on 9/8/22.
*She was discharged on 11/29/22 due to medical complications.
*She was readmitted on 3/19/23.
*During her stay from 9/8/22 to 11/29/22, there was no documentation regarding any of her behaviors.
*After she was readmitted, there was no documentation regarding negative behaviors such as refusing cares, hitting, kicking, pinching, spitting, throwing objects, or using abusive language prior to 6/14/23.
*There was no documentation of the verbal conversation from 6/23/23, mentioned above, in which the resident's daughter had been verbally informed of the resident's discharge.
*There was a progress note from 5/24/23 which stated, "Call placed to [primary care physician] per family [to] request for UA [urine analysis] test r/t [related to] increased incontinence and behaviors."
-The note did not specify what type of behaviors the resident had been exhibiting.
-A new order was entered on 5/27/23 for "Cephalexin Oral Tablet 500 MG [milligrams]. Give 1 tablet by mouth two times a day for UTI [urinary tract infection] for 7 Days."
--The second dose was not documented as being administered on 5/31/23 and 6/2/23 according to the resident's MAR.
*There were no behaviors documented until a progress note from 6/13/23 which stated, "Received call from facility that resident was not herself this morning. Slurring words, weak,

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confused. Advised to call family and have her seen."
-A follow-up progress note from the same day read, "Resident was seen at the ER [emergency room] and found to have an UTI new order received for Cefdinir 300 mg PO [by mouth] BID [twice a day] for 5 days was given first dose at ER pharmacy received order and will bring new medication today."
*A new order was initiated on 6/14/23 which read, "monitor for behaviors: refusal of cares, yelling, hitting, spitting etc. Make progress note if behaviors are present during your shift."
*There was a progress note from 6/14/23 which read, "Resident has been very moody and refusal of cares noted this AM. Resident would not allow staff to change her wet pull-up and when she would allow it her bottom was reddened. Resident responds very angrily when staff asks her to do things."
*There were progress notes entered for "good day," "nothing to report," and "none" on 6/17/23, 6/18/23, 6/21/23, 6/24/23, 6/25/23, 7/1/23, 7/3/23, and 7/9/23.
*There was a progress note from 6/23/23 which was struck out for the reason of "Declined Order" which read, "was in a good mood and let me help her with her new brief."
*There were progress notes entered for negative behaviors on 6/18/23, 6/19/23, 6/27/23, 6/28/23, 7/1/23, 7/3/23, 7/6/23, and 7/10/23. There was no new documentation to review after 7/10/23.
*There was no documentation about any discharge or transfer plans.
*An evaluation of care needs had not been completed since her readmission on 3/19/23.

Review of the provider's 2019 "Admission/Discharge Criteria" revealed:
*"B. [Facility's name] will not admit or retain

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residents who require care in excess of our specific license. Our facility may not admit or retain:"
-"3. Those who are disruptive in the facility and interfere with the care, and well-being of other residents."

Review of the provider's 2019 "Transfer and Discharge" policy revealed:
*"[Facility name], under the direction of the Administrator, will assist resident and/or responsible parties with discharge planning, as required by the Department of Health, when it becomes necessary for a resident to leave our communities."
*"We will have a discharge planning team, consisting of Administrator, a Registered Nurse, the Resident Care Manager, a direct care staff person, the resident and/or their responsible party, and the resident's primary physician, if deemed necessary by the other members of the team."
*"We will not transfer or discharge a resident unless the resident's needs and welfare cannot be met by the assisted living community, there resident's health has improved so that the resident no longer requires assisted living services, the safety, care or comfort of the resident or other residents is endangered by the resident..."
*"We will notify the resident and/or responsible party, in writing, at least ten (10) days before a medical discharge or thirty (30) days before a regular transfer or discharge... The written notice will specify the reason for, and the effective date of the transfer or discharge."
*"The resident may request or refuse transfers within the community by first contacting the community Manager in writing stating his/her reason for the request or refusal. If the resident's

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request or refusal are not honored by the manager, the resident may then write to the Board of Director's with his/her request or refusal."

2. Interview on 7/11/23 at 9:20 a.m. with licensed practical nurse (LPN) C about resident 1 revealed:
*She was trying to arrange the discharge of the resident to a neighboring nursing home due to the resident's "increased behaviors, resisting cares, attempts to hit, kick, bite, and spit."
*"[Resident 1] is above our level of care."
*There was an altercation on 6/27/23 when the resident had "punched" one of the aides in the side of the head.
-She had reported that incident to the South Dakota Department of Health as required, and notified the resident's daughter.
-Resident 1's daughter came to the facility and "yelled" at several staff, and physically poked LPN C in the chest "with force."
-At that point, LPN C had said to resident 1's daughter "We'll do 30 days."
*She was expecting the resident to be transferred on either 7/11/23 or 7/12/23.
-She was waiting on a call back from the receiving facility to finalize the transfer.
*They had issued a 30-day eviction notice to resident 1 on 6/27/23.

Observation and interview on 7/11/23 at 11:48 a.m. with resident 1 in her room revealed she:
*Was resting in bed.
*Was wearing her pajamas.
*Offered no complaints or concerns.
*Had mentioned that the staff was nice, and the food was good.
*Her room was neat, organized, clean, and there were no apparent odors.

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Interview on 7/11/23 from 2:56 p.m. to 3:49 p.m. with resident 1's daughter in the resident's room revealed:
*She was very complimentary of the staff and the facility.
*On 6/27/23, she had received a call from LPN C about the resident refusing a shower, and she had "slapped one of the staff."
-She went to the facility to offer assistance with her mother.
*Upon arriving at the facility, she found the resident's bed was soaked.
*She mentioned that she had found the resident's bed in a similar state on multiple occasions, yet the bed was always made when the sheets were soaked under the comforter.
-She stated that staff had informed her that the resident would wet the bed, and then make the bed on top of the soiled sheets.
-She stated she could not believe that her mother would have remade the bed.
*The facility served a 30-day eviction notice on 6/27/23.
-She received a copy of the notice in the mail.
*She said, "From my perspective, I was not being confrontational. From my perspective, they were the ones being confrontational."
*Neither she nor resident 1 wanted the resident to move out.
-Resident 1 was friendly with many of the other residents at the facility.
-Resident 1 liked the staff.

Interview on 7/12/23 at 8:27 a.m. with administrator A and LPN C about resident 1 revealed:
*She was "above their level of care."
*Administrator A said, "[Resident 1], we want to care for. The daughter makes it more

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 40563 | A. BUILDING: _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KELLY'S RETIREMENT II | 1522 EAST DAKOTA PIERRE, SD 57501 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 866 | Continued From page 34 | S 866 | | |

complicated."
*Resident 1 had an increase in negative behaviors since her readmission in March 2023.
-Administrator A said, "It's very hard to care for [resident 1]. She is more non-compliant than anything. Not so much with the aggression. It's more about the daughter."
*Neither administrator A nor LPN C offered any additional comments about the lack of behavioral documentation or assessment of needs to support their decision to serve the resident a 30-day eviction notice.

Interview on 7/12/23 at 10:28 a.m. with employees D and F about their dementia training and resident 1 revealed:
*They had been trained on identifying the early signs of dementia and how to handle a situation if a resident was exhibiting negative behaviors.
*They both said that they had never experienced aggression or resistance with care from resident 1.

Interview on 7/12/23 at 11:06 a.m. with employee H about providing care for resident 1 revealed:
*Resident 1 was resistant to assistance with care because she liked to try to do things for herself first.
*She mentioned there were a couple of times where resident 1 had pinched her, or kicked in her direction during care.
-She did not "take it to heart."
-She thought of the actions more as joking around, because resident 1 had been known to do that with staff.

Interview on 7/12/23 at 1:07 p.m. with administrator A about resident 1 revealed:
*It was not set-in-stone yet, but "at this point we are not going to discharge [resident 1]."

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|---|---|---|---|
| | 40563 | A. BUILDING: _____ B. WING _____ | C 07/12/2023 |

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|---|---|
| KELLY'S RETIREMENT II | 1522 EAST DAKOTA PIERRE, SD 57501 |

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|---|---|---|---|---|
| S 866 | Continued From page 35<br>*His biggest issue was with resident 1's daughter, not resident 1.<br>*"We like [resident 1] and can take care of her."<br>*He agreed staff needed to improve on consistently documenting resident 1's behaviors. | S 866 | | |

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 |
|---|---|---|---|
| | 40563 | A. BUILDING: _____ B. WING _____ | R 09/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KELLY'S RETIREMENT II | 1522 EAST DAKOTA PIERRE, SD 57501 |

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|---|---|---|---|---|
| {S 000} | Compliance Statement<br><br>An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 9/20/23 for deficiencies cited on 7/12/23. All deficiencies have been corrected, and no new noncompliance was found. Kelly's Retirement II is in compliance with all regulations surveyed. | {S 000} | | |

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