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
	10744	A. BUILDING: _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAIL RIDGE RETIREMENT COMMUNITY	3400 RALPH ROGERS ROAD SIOUX FALLS, SD 57106

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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 from 9/16/24 through 9/18/24. Trail Ridge Retirement Community was found not in compliance with the following requirements: S030, S096, S201, S450, S685 and S837. 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 9/16/24 through 9/18/24. Areas surveyed included abuse, neglect, elopements, and pest control. Trail Ridge Retirement Community was found in compliance.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report 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 other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas.	S 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Patten	Administrator	10/07/2024

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S 030	Continued From page 1 The facility shall conduct an internal investigation for 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 observation, interview, care record review, and policy review, the provider failed to report two events involving one of one sampled resident (3) who was at risk for potential abuse and neglect to the South Dakota Department of Health (SD DOH). Findings include: 1. Observation and interview on 9/16/24 at 11:25 a.m. with resident 3 in her room revealed two cameras. One camera was placed above the living room window and the second camera was placed above the entrance door leading into her room. Resident 3 confirmed she knew the cameras were in her room but she was not sure why. 2. Review of resident 3's care record revealed: *An admission date of 3/4/24. *She was cognitively intact. *Her diagnoses included post femoral fracture, depression, atrial fibrillation, and anxiety. Review of the following nursing progress notes on the following dates and times for resident 3 revealed on: *8/30/24 at 1:09 p.m.: -"Received a call from resident's son, [name], with resident also on the call.	S 030		

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S 030	Continued From page 2 -[Son's name] said that resident stated another resident had just been in her room and grabbed her arm and touched her breast. -I told [son's name] that staff have been monitoring the hallway and will review the cameras to see if another resident had entered this resident's room. -This resident then stated "just forget it, just forget I said anything." -Writer went to resident's room and closed her door which she had propped open." *9/9/24 at 11:05 a.m.: -"Reported in 9/8/24 day shift; When I was returning her laundry to her room the door was locked. -I waited until the [visitor] came to the door to open it to give them their privacy. -Her [visitor] opened the door with his/her pants unbuckled with no underwear on, exposing too much of himself/herself. -I was then in the bedroom putting away her clothes when [residents name] [visitor] came in and stood in the doorway of the closet just watching me. -Then he/she was pushy about getting me out of the room." 3. Review of resident 12's care record revealed: *An admission date of 6/28/23. *He had diagnoses of Alzheimer's disease, dementia, and behavioral disturbance. *He had inappropriate interactions with staff and residents. Review of resident 12's service plan revealed he: *Had sexual behaviors toward staff and female residents. *Was not to be left alone in female residents rooms. *Was to be accompanied by his wife or a staff	S 030	POC S030: Affected Resident: R12 is no longer a resident of the facility. R3's incident was reported to DOH as well as the incident regarding the visitor of R3. R3's service plan was reviewed and remains current. Potential Affected Resident(s): All residents have the potential to be affected by reporting of incidents. All residents' care records were reviewed, and interventions adjusted as needed. Measures/Systematic Changes: The Abuse and Neglect Policy was reviewed and remains current. All staff will review the Abuse and Neglect policy and the need to report incidents to the supervisor. All incidents (if any) since exit have been reviewed for need to report. All incidents will be reviewed each business day by the administrator and any incident meeting the reporting requirement of the department of health will be reported in accordance with State Law.	10/15/24

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S 030	Continued From page 3 member when out of his room. 4. Interview on 9/17/24 at 9:30 a.m. with registered nurse D regarding the cameras in resident 3's room revealed: *Her son had put the cameras into her room on 9/15/24. *They had not noticed the cameras until 9/16/24 and then they put the note on the door. *All the staff were alerted to the cameras in her room. Interview on 9/17/24 at 10:45 a.m. with administrator A and director of nursing B regarding resident 3 revealed: *There was a discussion with the son indicating he would be putting a camera into her room. *Resident 3 had told them last week another male resident (12) had touched her on the breast. *They had discussed interventions with her. *The interventions for resident 12 had included: -Medication changes after being seen by his physician. -Monitoring his behaviors and whereabouts. *Resident 12 could not confirm the incident had happened due to his cognitive ability. -There had been other episodes that had been reported to them regarding inappropriate contact between resident 12 with other residents. *They had reviewed their cameras out in the hall and it had revealed resident 12 had "Helped her into her room" and remained in the room for a very short time, maybe a minute or two. *It had been reported a week ago a visitor had been inappropriate when a caregiver had gone to resident 3's room. *They had: -Called the police. -Met with the son regarding the alleged incident between resident 12 and his mother.	S 030	POC S030 cont: Monitoring: Audits of all incidents for need to report will be conducted each business day for 4 weeks and then weekly for an additional 4 weeks. Administrator is responsible for compliance. Results of monitoring will be reported at the QA meeting monthly with ongoing frequency and duration to be determined through analysis and review of results.	

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S 030	Continued From page 4 -Met with resident 3 and told her the visitor needed to be appropriately dressed or else they would be contacting the police. *Resident 3 had "not shared much with them during the conversation." -Met with resident 3's visitor and told him/her they needed to be appropriately dressed or else they would be contacting the police. *They had contacted the ombudsman. *They had not reported either of the two incidents to the SD DOH. *They should have reported both incidents to the SD DOH. *Resident 12 would be discharged from their facility on 9/20/24 because he was over-level-of care they provided. 5. Review of the provider's August 2024 Abuse and Neglect policy revealed "Alleged violations involving any mistreatment, neglect, or abuse including injuries of unknown source, will be reported immediately to the facility administrator and to other officials in accordance with State Law."	S 030		
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 5 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to: *Secure cleaning chemicals in a safe manner in one of two housekeeping carts by one of one observed nursing assistant (NA) (G). *Prevent cross-contamination while cleaning a resident room by one of one observed NA (G). Findings include: 1. Observation and interview on 9/17/24 at 7:25 a.m. in the assisted living wing with housekeeper F revealed: *She had a housekeeping cart with cleaning chemicals stored in a caddy on top of her cart. -The cleaning chemicals were brought into each residents room when she cleaned. -Cleaning chemicals were never left unattended on the housekeeping cart. 2. Observation and interview on 9/17/24 at 1:45 p.m. with NA G in the north memory care unit revealed: *She worked as a nursing assistant in the morning and worked as a housekeeper in the afternoon. *She had gone to get a premixed cleaning chemical for the mop. -When she returned she placed the bucket with the cleaning chemical on the bottom ledge of the housekeeping cart. *She pushed the housekeeping cart to room 102. She: -Gathered the toilet bowl cleaner and window spray and entered the room. -Had not performed hand hygiene before putting	S 096	POC S096: Affected Resident(s): Assisted Living and Memory Care units were cleaned and inspected. No residents had adverse effects related to the reported cleaning methods. Potential Affected Residents: All residents have the potential to be affected by housekeeping cleaning methods. Measures/Systemic Changes: The Hand Hygiene Policy was reviewed and remains current. The Housekeeping Policy was reviewed and revised. All housekeeping staff will review the Hand Hygiene policy. All housekeeping staff will review the Housekeeping Policy.	10/14/24

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S 096	Continued From page 6 on a pair of gloves. -Sprayed the toilet bowl cleaner into the bowl. -Took the toilet bowl brush, swished the brush around in the toilet bowl, and then placed the toilet bowl brush back into the holder. -Picked up the toilet bowl cleaner, went to the housekeeping cart, placed the toilet bowl cleaner into the opened container on the housekeeping cart, and without securing the container with all of the cleaning chemicals in it returned to the room. *With those same gloved hands she used to clean the toilet bowl, picked up the window spray cleaner, sprayed the faucet, mirror, and sink counter. She then: -Took a cloth and wiped the mirror, the sink, and the sink counter. --She picked up the resident's personal belongings including a water glass, lotion, and toothpaste. *She then: -Returned to the housekeeping cart and placed the window spray into the opened container with the rest of the cleaning chemicals. -Took the bucket containing the cleaning solution and poured it into the mop holder. -Placed the bucket with the remaining cleaning solution back on the bottom shelf of the housekeeping cart. -Returned to the resident's room, continued to dust items, then mopped the bathroom floor and then the main living area floor. -Returned to the housekeeping cart, removed the gloves she had worn during the entire cleaning observation, and performed hand hygiene. Interview at that time with NA G regarding the above observed cleaning of room 102 revealed: *The door to room 102 had been closed while she was cleaning the room and she was unable to see the housekeeping cart.	S 096	S 906 cont: Monitoring: Audits of all housekeeping carts for securing of chemicals will be conducted 3 days/week for 4 weeks and then weekly for an additional 4 weeks. Audits of the housekeeping process will be conducted 3 times/week for 4 weeks and then weekly for an additional 4 weeks. Environmental Services Director is responsible for compliance. Results of monitoring will be reported at the QA meeting monthly with ongoing frequency and duration to be determined through analysis and review of results.	

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S 096	Continued From page 7 *She had left the housekeeping cart unattended with cleaning chemicals that were not secured. *She agreed she should have removed her gloves, performed hand hygiene, and put on new gloves before she continued to clean the room. Interview on 9/17/24 at 4:50 p.m. with administrator A and registered nurse/nurse educator N regarding the above observations revealed they agreed: *The housekeeping cart supplies on the north memory care unit should have been locked and out of residents' reach. *NA G should have removed her gloves, performed hand hygiene, and put on new gloves before she continued to clean the resident's room. Review of the provider's undated Housekeeping policy revealed: *"Cleaning supplies and appropriate cleaning tools (e.g., vacuum, mop, dusters, disinfectants) will be available and kept secure when not in use. Cleaning agents will be used according to the manufacturer's recommendations and solutions shall be labeled and stored in a safe place." *Procedure: -3. "Dust surfaces." -6. "Wipe down the bathroom sink, faucet, countertop, and mirrors with glass cleaner or a disinfectant spray." -8. "Use toilet cleaner to scrub the inside of the toilet bowl." -9. "Wipe down the toilet seat, lid, and handle with disinfectant wipes." -11. "Mop kitchen/living area." -12. "Mop the bathroom floor." Review of the provider's 3/6/24 Hand Hygiene policy revealed:	S 096		

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S 096	Continued From page 8 *"Hand Hygiene is the primary means to prevent the spread of infection." *5. "Use alcohol-based hand sanitizers: -Before moving from a contaminated body site to a clean. -Before and after glove use."	S 096		
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. This Administrative Rule of South Dakota is not met as evidenced by: A.) Based on observation, testing, and interview, the provider failed to maintain the fire-resistive design of one randomly observed building separation wall (West Assisted Living Center [ALC] wing). Findings include: 1. Observation and testing on 9/18/24 at 9:43 a.m. revealed the south leaf of the cross-corridor doors in the two-hour fire-rated separation wall between the west ALC wing and the central core did not close and latch on three of three attempts. That door is required to close and latch to maintain the fire-resistive design of that wall assembly. Interview with the maintenance supervisor at the	S 201	POC S 201: Potential Affected Resident(s): All residents have the potential to be affected by not following fire safety guidelines. Measures/Systemic Changes: South leaf of cross corridor doors of AL West wing was adjusted to allow proper latching and maintain fire safety. All 2-hr fire rated cross corridor doors were checked, and all doors latched properly.	10/20/24

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S 201	Continued From page 9 time of the observation and testing confirmed those findings. B.) Based on observation, testing, and interview, the provider failed to maintain the smoke resistive design of three randomly observed the resident room corridor doors (138, 118, and 131). Findings include: 1. Observation and testing of the corridor door to resident room #138 on 9/18/24 at 10:02 a.m. revealed it did not close and latch into the doorframe and did not maintain its smoke resistive design. 2. Observation and testing of the corridor door to resident room #118 at on 9/18/24 10:18 a.m. revealed it did not close and latch into the doorframe and did not maintain its smoke resistive design. 3. Observation and testing of the corridor door to resident room #131 at on 9/18/24 10:38 a.m. revealed it did not close and latch into the doorframe and did not maintain its smoke resistive design. Interview with the maintenance supervisor at the same time of the observations and testing confirmed those findings. C.) Based on observation, testing, and interview, the provider failed to maintain impediment-free closing for four randomly observed corridor doors (ALC Activities office, Nurses Station, M118, and M109) as required. Findings include: 1. Observation on 9/18/24 at 11:02 a.m. revealed the corridor door to the activities office had an extension cord ran through the door frame.	S 201	POC S 201 cont.: AL 138 door was adjusted to ensure proper closing and latching. AL 118 door was adjusted to ensure proper closing and latching. AL 131 door was adjusted to ensure proper closing and latching. All doors in AL were checked and adjusted to ensure proper closing and latching. Extension cord was removed from the activities office. Fire Prevention Policy reviewed and revised. All staff will review Fire Prevention Policy at October all-staff meeting. Door wedge removed from nurse office. Door wedge removed from MC 118. Door wedge removed from MC 109. All doors were checked, and door wedges were removed. Residents and family received notification and information regarding fire safety.	

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S 201	Continued From page 10 Testing of that door revealed the cable would bind the door before it could latch into the frame. 2. Observation on 9/18/24 at 11:11 a.m. revealed the corridor door to the nurses office had rubber door wedge placed under the door. Testing of that door revealed the wedge would bind the door before it could latch into the frame. 3. Observation on 9/18/24 at 11:20 a.m. revealed the corridor door to resident room #M118 had rubber door wedge placed under the door. That door wedge would inhibit the immediate closing of the door to prevent the spread of fire and smoke. 4. Observation on 9/18/24 at 11:26 a.m. revealed the corridor door to resident room #M109 had rubber door wedge placed under the door. That door wedge would inhibit the immediate closing of the door to prevent the spread of fire and smoke. Interview with the maintenance supervisor at the same time of the observations and testing confirmed those findings. D.) Based on observation, and interview, the provider failed to maintain nominally level walking surfaces for one randomly observed exit (northeast exit into the "courtyard") as required. Findings include: 1) Observation at 11:33 p.m. on 9/18/24 revealed the path of egress for the northeast exit of north memory care unit had a step down of approximately two inches in between the sections of concrete. That condition created a less than nominally level walking surface in the path of egress with an abrupt change of elevation greater than one quarter of an inch and was not accomplished by a slope or step. LSC 7.1.6.3(1)	S 201	S 201 cont.: Egress for NE exit of S MC will be repaired. All exits were checked for appropriate path of egress and corrections will be made as necessary. Monitoring: Maintenance staff will check the 2-hr fire rated cross-corridor doors monthly for the next six months to ensure proper latching. Maintenance staff will check 7 corridor doors weekly for four weeks to ensure doors close and latch to maintain smoke resistive design. Maintenance will check 7 doors/week for 4 weeks to ensure that no obstacles are available that would impede the closing of the doors. Maintenance staff will check two exits monthly for 3 months for proper egress and level walking surface. The ES Director is responsible for compliance. Results of monitoring will be reported at the QA committee meeting monthly with ongoing frequency and duration to be determined through analysis and review of results.	

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S 201	Continued From page 11 Interview with the maintenance supervisor at the same time of the observations and testing confirmed those findings.	S 201	S 450: Affected Residents: No residents had adverse effects related to the reported kitchen sanitary methods. Potential Affected Residents: All residents have the potential to be affected by the kitchen sanitation methods. Measures/Systemic Changes: Kitchen Cleaning Policy reviewed and remains current. All nursing staff will review Kitchen Cleaning Policy Hand Hygiene Policy was reviewed and remains current. All nursing staff will review the Hand Hygiene Policy. Food Temperature Policy was reviewed and remains current. All nursing staff will review the Food Temperature Policy. Hair Restraint Policy was reviewed and revised. All nursing staff will review the Hair Restraint Policy. The Food Label Policy was reviewed and revised. All nursing staff will review the Food Label Policy.	10/31/24
S 450	44:70:06:01 Dietetic Services 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. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, food logs, cleaning logs, and policy review, the provider failed to maintain a safe and sanitary food service environment in two of two kitchens related to: *Maintaining one of two kitchens (assisted living) in a clean and sanitary manner. *Hand hygiene by one of one dietary assistant (H) during one of three meal service preparations. *Ongoing monitoring of refrigerator and freezer temperatures for two of two kitchens. *Ongoing monitoring of food temperatures before being served to residents in two of two kitchens. *Food items were appropriately covered when transported from one of two kitchens (memory care) to one of two memory care dining rooms (north memory care). *Food items were dated when opened in two of two kitchens. Findings include: 1. Observation and interview on 9/16/24 at 4:30 p.m. in the assisted living kitchen with dietary assistant H revealed:	S 450		

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TRAIL RIDGE RETIREMENT COMMUNITY	3400 RALPH ROGERS ROAD SIOUX FALLS, SD 57106

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S 450	Continued From page 12 *The ice machine had areas of corrosion on the grates, faucet and water dispenser. *The freezer had frozen pieces of ice cream on the floor of it. *There was a large undated uncovered Styrofoam cup containing vanilla ice cream. *The outside door handle of the freezer was sticky. *The cereal dispenser contained cereal that was dated 4/30. *The toaster on the counter had one piece of cold toast inside of it. *The small ice cream freezer had dried and spilled material on top of it. The inside of that small ice cream freezer: -Contained two three-gallon containers of ice cream. --The vanilla ice cream container had been opened. --There was no date when it had been opened. --The lid to the container was not closed completely. --There was ice cream frozen to the outside of the ice cream container. *The small freezer containing the frozen waffles and french toast had a large amount of debris and crumbs on the bottom. *The small cooler containing salad preparation food supplies had a container with four hard boiled eggs in it. -There was not a cover over the eggs. -The eggs had not been dated. -One egg was crumbled in half. -The container was visibly dirty. *The small refrigerator containing salad dressing had two one-gallon containers. -The french dressing had been dated as being opened on 8/5/24. -The Thousand Island dressing had not been dated when opened.	S 450	POC S 450 cont.: Food items will be covered when transporting from the MC kitchen to the N MC across the hallway. Kitchen staff will complete a kitchen cleaning checklist on each shift. Ice machine will be cleaned with scale remover. Ice cream freezer will be cleaned on the interior and exterior. Styrofoam cup of vanilla ice cream was discarded. Freezer door handle was cleaned. Cereal in dispenser was discarded and dispenser was cleaned. Fresh cereal was added and dated accordingly. Toast was discarded. All food without date was discarded. Ice cream lid is closed tightly. Small freezer that contains waffles was cleaned. Eggs were discarded. All items stored on the salad preparation table will be covered and labeled. Salad table was cleaned. Thousand Island dressing without date was discarded.	

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S 450	Continued From page 13 -Both salad dressing containers had a large amount of salad dressing on the outside of the containers and on the sides of the containers. -The small refrigerator was sticky and dirty. *The insides of two of two plate warmers containing the plates used to serve the residents' meals were dirty with dried spills. *The grate under the juice machine was dirty and rusty. *On the dining room area outside of the kitchen: -The refrigerator/freezer had several opened condiments with no date to support when they had been opened. *The oven had crumbs and was visibly dirty. *There was no hand sanitizer in the wall dispenser outside the kitchen door. *Dietary assistant H: -Had worked at the facility for one year. -Did not know if the dishwasher was high temperature controlled or chemical controlled for cleaning and sanitizing the dirty dishes. -Did not know who was responsible for cleaning the kitchen. Continued observation on 9/16/24 at the following times in the assisted living kitchen revealed: *At 5:06 p.m.: certified medication aide (CMA) I came into the kitchen. She was not wearing a hair covering. -She went to coffee machine and poured hot water into a Styrofoam cup and mixed hot chocolate mix into it. -She then went to the refrigerator and removed a pitcher of ice tea and began to pour it into glasses. -The steam table containing food was adjacent to the refrigerator and coffee machine. *At 5:08 p.m. dietary assistant H: -Had on a pair of gloves. -Began to place coleslaw into Styrofoam dishes	S 450	POC S 450 cont.: Salad dressing containers were cleaned. Plate warmers were cleaned. New grates for both juice machines have been ordered and will be replaced. The fridge in the AL dining room will be checked for unlabeled items. Anything unlabeled will be discarded. The oven will be cleaned. The hand sanitizer by the AL kitchen door was replaced.	

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S 450	Continued From page 14 while occasionally touching the inside of those Styrofoam dishes. -Commented "They always serve coleslaw in Styrofoam dishes." *At 5:14 p.m. CMA I was filling a coffee carafe and spilt coffee on the floor. -Dietary assistant H: --Had been preparing food for the evening meal when he picked up a mop and cleaned up the spill on the floor. --With the same pair of gloves he had been wearing since 4:30 p.m., he returned to preparing residents' food. --Began to ladle soup into bowls while touching the inside of the bowls and the vegetables on the ladle. *At 5:17 p.m. dietary assistant H placed the serving utensils on the board in front of the steam table. -The board had several cut grooves in it making it uncleanable. -The board was visibly discolored to a yellow-brown color. *At 5:20 p.m. dietary assistant H began to plate the residents' items with those same gloved hands. -While plating the food items, he would take his gloved hand and place a piece of lemon on each individual plate. -He touched the inside of the plates with those same gloved hands and continued that throughout the plating of the food items. Observation on 9/17/24 at 7:10 a.m. in the memory care kitchen revealed: *The door leading into the kitchen was opened. *There was no staff in the kitchen. *There were three cereal dispensers full of cereal that were not dated. *The eggs and the oatmeal in the steamtable	S 450	Staff will be educated that styrofoam dishes are not to be used. Ample dishes are available. Cutting boards at the front edge of both steam tables will be replaced. Door leading to MC kitchen will be closed. Cereal in dispensers will be discarded. Dispensers will be washed and restocked with fresh cereal and dated accordingly.	

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S 450	Continued From page 15 were covered with a plastic wrap. *The ice machine had areas of corrosion on the grates, faucet, and water dispenser. *The grate under the juice machine was dirty and rusty. *The September 2024 refrigerator and freezer temperature log posted on the outside of the refrigerator had several days where temperatures had not been recorded. *The north memory care dining room refrigerator handle was broken. Observation and interview on 9/17/24 at 8:05 a.m. in the memory care kitchen with director of nursing (DON) B and nursing assistant (NA) G revealed: *The eggs and the oatmeal in the steam table were partially covered with plastic wrap and a serving utensil was in each container. -No one was plating food at that time. *DON B: -Was in the kitchen. -Did not have a hair covering on. -Stated she was "cleaning up the kitchen." -Confirmed she did not have a hair covering on but should have. -Confirmed the monthly food temperature log on the front of the refrigerator had several dates without a temperature recorded and should have. -The lead kitchen person for the assisted living kitchen was CMA M and the lead kitchen person for the memory care kitchen was CMA E. -Had not looked at the food and refrigerator/freezer temperature logs in a long time. *NA G confirmed she: -Had not checked the temperature of the hot food after the food had been placed into the steamtable and before it was served. -Should have checked the temperature of the hot	S 450	POC S 450 cont. Ice machine in MC will be cleaned with scale remover. New grates have been ordered to replace the grates in the juice machine in MC. The N MC dining room refrigerator door handle will be fixed or replaced. Plastic or foil coverings on the food for the steam table will be removed and replaced with lids immediately after transport to satellite kitchens.	

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S 450	Continued From page 16 food before serving it to the residents. Observation and interview on 9/17/24 at the following times in the memory care kitchen with NA G and CMA J revealed at: *11:30 a.m. : NA G took a food thermometer and then poked the thermometer through the plastic wrap to check the food temperatures. -She continued that same process with the soup, lasagna, cheesy baked potatoes, and the vegetables. *11:35 a.m.: NA G began to plate the resident's food for the south memory care. -CMA J took the plated food for the residents, opened a door leading into the south memory care, and delivered it. --This continued until the south memory care residents were all served. *11:45 a.m.: NA G began to plate the resident's food for the north memory care. -CMA J took the food without being covered, walked through the main hallway, through a short hallway, and though a door into the north memory care. --This continued until the north memory care residents were all served. *11:50 a.m.: Interview with NA G confirmed she: -Never covered the food when it left the kitchen to be delivered to the north memory care. -Had not thought of the potential of cross-contamination of uncovered food. Review of the Fridgerator/Freezer Temperature records and the temperatures of the food for the assisted living kitchen and the memory care kitchen revealed for the: *Assisted living kitchen from July 2024 through September 17, 2024: -There were several times the temperatures for the refrigerators and the freezers had not been	S 450	Monitoring: Cleaning checklists and cleaning compliance will be reviewed weekly for 4 weeks. Then checklists and compliance will be checked be checked monthly for 5 months. The fridge/freezer temp logs of both the AL and MC kitchens will be checked weekly for 4 weeks. Then the logs will be checked monthly for 5 months. The food temp logs of both the AL and MC kitchens will be checked weekly for 4 weeks. Then the logs will be checked monthly for 5 months. Proper hand hygiene in the kitchen will be assessed 2 times/week for 4 weeks to ensure compliance. Proper lids are on the food in the steam table will be checked 3 times/week for 4 weeks. The use of styrofoam dishes at mealtimes will be checked 3 times/week for 4 weeks. Both the AL and MC satellite kitchens will be checked for foods to be properly dated 3 times/week for 4 weeks. Food being transported across the hallway to the MC North dining room will be checked to ensure that is it covered 3/week for 4 weeks.	

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S 450	Continued From page 17 documented indicating it had not been done. -The food temperature log for: -- August 2024 had been partially documented on August 8, 11, 18, and 26th. There were no other documentation of food temperatures provided for August 2024. --September 2024 had been partially documented on September 1, 8, and 15. There were no other documentation of food temperatures provided for September 2024. *Memory care kitchen for September 2024 revealed: -The coolers and refrigerator/freezer temperatures had been recorded five out of seventeen days. -The food temperature logs had been partially documented on from September 1 through 17, 2024. Interview on 9/18/24 at 7:50 a.m. with administrator A regarding the above observations revealed: *They were to never use Styrofoam dishes unless of an emergency. They were to always use the china. *Her expectations were for the kitchens to be clean and sanitary. Interview on 9/18/24 at 9:00 a.m. with director of dining services L regarding the above observations revealed: *They should not use Styrofoam dishes unless used for residents in isolation or an emergency. *He agreed the kitchen should have been cleaned. -The staff had a cleaning list they were to use. -The food temperatures should not have been checked through the plastic wrap with the potential of particles ending up in the food. -Serving utensils should not be left in the food for	S 450	Monitoring cont.: The ADON is responsible for compliance. Results of the monitoring will be reported to the QA committee monthly with ongoing frequency and duration to be determined through analysis and review of results.	

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S 450	Continued From page 18 the potential of cross-contamination. -The staff were to follow their Hand and Glove policy. --Dietary assistant H should have removed his gloves and performed hand hygiene after mopping up the floor. -The kitchen staff were not to touch the food with their gloved hands after touching multiple surfaces to prevent cross- contamination. -The refrigerator and freezer temperatures should have been checked, monitored, and documented. -The juice machines were "rented" and he would be checking into new juice machines. *He oversaw the main kitchen in the independent living side. The assisted living kitchen and the memory care kitchen were overseen by director of nursing B. *He did not think the food delivered to the north memory care kitchen needed to be covered. *They did not have a log of when or who had cleaned the: -Kitchen so they were unable to monitor the cleaning of them. -Ice machine so they were unable to monitor the cleaning of it. Review of the provider's undated Food Temperature policy revealed: *The purpose was "To ensure all foods are prepared, stored, and served at safe temperatures, preventing foodborne illnesses and ensuring compliance with health and safety regulations." *1. "All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees." -c. "Food temperatures will be taken and recorded in the log book prior to each meal service. Includes the date time, food item, temperature recorded, and initials of the staff	S 450		

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S 450	Continued From page 19 member responsible." *3. "Food should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e., hot/cold carts, pellet systems, insulated plate bases and domes, etc.). Review of the provider's undated Labeling and Dating of Food policy revealed: *"Food will be labeled and dated to ensure safe, wholesome and appetizing," *Purpose: -1. "All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. -2. The current date should be marked on food items at the time of opening. -3. Food items that are beyond 7 days of opening should be discarded." Review of the provider's undated Bare Hand Contact with Food and Use of Plastic Gloves policy revealed: *"Single use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served." *3. "Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single-use gloves shall be used for only one task (such as working with read-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation." *6. "Anytime a contaminated surface is touched, the gloves must be changed, and hands must be	S 450		

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S 450	Continued From page 20 washed: -d. after handling anything soiled." Review of the provider's 11/14/23 Kitchen Hand Washing policy revealed: *"Hands are exposed portions of arms should be washed immediately before engaging in food preparation. -1. When to wash hands: --j. After engaging in other activities that contaminate the hands." Review of the provider's undated Production, Storage, and Dispensing of Ice Policy revealed: *"Ice will be produced, stored, and dispensed in a manner to avoid contamination." *1. "The ice dispenser exterior will be cleaned and sanitized at least weekly, and or as needed. The outside of the machine and the area around the machine will be cleaned." A request for the Kitchen Cleaning policy, Kitchen Cleaning Checklist and document that supported the staff had cleaned the kitchen had been requested from administrator A on 9/17/24 at 1:10 p.m. The provider provided an undated blank Kitchen Cleaning Checklist. They had not provided a Kitchen Cleaning policy or a completed Kitchen Cleaning Checklist supporting the staff had cleaned the kitchen by the end of the survey..	S 450		
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	S 685		

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S 685	Continued From page 21 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 self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure three of eleven sampled residents (13, 19, and 20): *Were assessed to determine their ability to self-administer medications. *Had a current physician order allowing them to self-administer the medications. Findings include: 1. Observation and interview on 9/16/24 at 2:00 p.m. with registered nurse (RN) D regarding resident 13's medications revealed: *The medications to be administered by the nurse or medication aides were in a locked drawer in her room. -This was the process in all assisted living rooms. *There were multiple medications that this resident had been allowed to self-administer. -These medications were observed sitting out on the resident's dresser with a copy of the medication administration record (MAR).	S 685		

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S 685	Continued From page 22 -The resident would mark off when she took the self-administered medication. *RN D stated that self-administration assessments were completed quarterly or sooner if the resident's condition changed. 2. Review of the care record for resident 13 revealed: *She had been admitted on 11/21/22. *Her 7/21/24 brief interview for mental status (BIMS) assessment revealed a score of 15 indicating she was cognitively intact. *Her last self-administration assessment with physician order had been completed on 6/14/23. *There was no current self-administration assessment or a physician order for self-administration for the following medications: -Saline deep sea nasal spray, one spray in each nostril once daily as needed. -Sennokot Gummies, two gummies every twenty-four hours as needed. -Tums Ultra, one tablet three times a day as needed. -Acetaminophen 500 milligram (mg), one tablet two times a day as needed. -Cinnamon supplement 500 mg, two capsules daily. -CoQ10 200 mg, one capsule daily. -Aspirin 81 mg, one tablet daily. -Calcium and Phosphorus with Vitamin D 250/100/500 mg gummies, two gummies daily. -Vitamin B-12 1000 microgram (mcg), one tablet daily. -Vitamin C Gummies, two gummies daily. -Cranberry supplement 400 mg, one tablet daily. -Curcumin 95 (turmeric) supplement, one capsule daily. -Albuterol inhaler, two puffs every four hours as needed. -Albuterol nebulizer, one vial via nebulizer every	S 685	POC S 685: Affected Residents: Self-administration assessment was completed for resident 13. Physician order for self-administration was received for resident 13. Self-administration assessment was completed for resident 19. Physician order for self-administration was received for resident 19. Self-administration assessment was completed for resident 20. Physician order for self-administration was received for resident 20. Potential Affected Residents: All residents who self-administer medications were checked for up-to-date assessments. An assessment was completed and a physician's order was received by those not in compliance. Measures/Systemic Changes: The Administration Medication Policy was reviewed and remains current. The Medication Administration Policy will be reviewed by all nurses.	10/10/24

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S 685	Continued From page 23 four hours as needed. -Salon Pas gel, three times daily as needed. -Fluticasone spray 50 mcg, one spray in each nostril at bedtime as needed. -Latanoprost solution 0.005%, one drop in each eye at bedtime. *She had been marking the above medications as taken on her copy of the MAR. 3. Review of the care record for resident 19 revealed: *She had been admitted on 3/1/24. *Her 7/24/24 BIMS assessment revealed a score of 15 which indicated she was cognitively intact. *There was no self-administration assessment or physician order to self-administer medications. *The resident had been self-administering the following medications and marking them as completed on her MAR: -Albuterol nebulizer, 1 vial via nebulizer daily. -Aspirin 81 mg, daily. -Astaxanthin 4 mg, two capsules daily. -Atenolol 12.5 mg, daily. -Atorvastatin 40 mg, daily at bedtime. -Calcium Magnesium 500 mg/250 mg, one tablet by mouth daily. -CoQ10 200 mg, one tablet daily. -Culturelle, one capsule daily. -Fluticasone/Vilanterol 200 mcg/25 mcg, one puff at bedtime. -Levothyroxine 50 mcg, one tablet daily. -Lutein 20 mg, two capsules daily. -Oregano supplement, one capsule daily. -Rosuvastatin Calcium 10 mg, one tablet daily. -Ruby Oil 500 mg supplement, two capsules daily. -Vitamin B-12 1000 mcg sublingual, one tablet daily. -Brilinta 60 mg, one tablet twice daily. -Eliquis 5 mg, one tablet every twelve hours.	S 685	S 685 cont.: Monitoring: Care records will be audited monthly for 6 months to ensure the quarterly assessment is completed and the physician's order is on file. The DON will be responsible for compliance. Results of the monitoring will be reported to the QA committee monthly with ongoing frequency and duration to be determined through analysis and review of results.	

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TRAIL RIDGE RETIREMENT COMMUNITY	3400 RALPH ROGERS ROAD SIOUX FALLS, SD 57106

(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 685	Continued From page 24 -Metoprolol 25 mg, three tablets twice a day. -Pantoprazole 40 mg, one tablet twice a day. -Acetaminophen 325 mg, two tablets every four hours as needed. -Albuterol inhaler, two puffs six times a day as needed. -Antacid 30 milliliters (ml), two times daily as needed. -Cetirizine 10 mg, one tablet daily as needed. -Hyoscyamine sublingual 0.125 mg, one tablet four times a day as needed. -Milk of Magnesia 400 mg/5 ml, 30 ml as needed. 4. Review of the care record for resident 20 revealed: *She had been admitted on 4/18/19. *Her 9/9/24 BIMS assessment revealed a score of 15 which indicated she was cognitively intact. *The last self-administration assessment and physician order for self-administration had been completed on 5/18/24. *There was no self-administration assessment completed in August 2024 for the following medications: -Muscle milk supplement, one can as needed if resident does not eat the meal served. -Petroleum jelly, topically as needed. -Tube foam, to toes for use with footwear as needed. 5. Interview on 9/18/24 at 8:40 a.m. with director of nursing B regarding the self-administration of medications revealed: *An up-to-date assessment for resident 13 had not been completed. *The assessment for resident 19 had been placed on the nurse calendar to have been completed on 8/18/24 but was not completed. *An assessment was to have been completed for resident 20 when she returned from the hospital	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10744	A. BUILDING: _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAIL RIDGE RETIREMENT COMMUNITY	3400 RALPH ROGERS ROAD SIOUX FALLS, SD 57106

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S 685	Continued From page 25 on 9/9/24 but was not completed. *She acknowledged that the three assessments for residents 13, 19, and 20 had not been completed in a timely manner. -It was the intention of RN D to complete them as soon as possible. *It was her expectation that a nurse complete a self-administration assessment every three months and as needed. Review of the provider's 3/7/24 Assisted Living Medication policy revealed: *"RN will complete Assessment for self-administration of medication upon initial request to self-administer and at least every three months. *Assessment for Self-administration of medications will also be signed by the resident's physician, physician assistant, or nurse practitioner,. *Assessment will be completed after significant change in condition or hospitalization."	S 685		
S 837	44:70:09:09(3) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: (3) Freedom from physical or chemical restraints imposed for purposes of discipline or convenience; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record	S 837		

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S 837	Continued From page 26 review, and policy review, the provider failed to ensure one of one sampled resident (3) had a physician's order and updated service plan for the continued use of an assistive device on her bed. Findings include: 1. Observation and interview on 9/16/24 at 11:25 a.m. in resident 3's room revealed a bed with a U-shaped bar attached to it. *There was a piece of fabric approximately twelve inches wide attached to the side rods of the U-shaped bar. *The fabric was not attached on one side which left a gaping hole between the rods of the U-shaped bar. *Resident 3 stated she had used the U-shaped bar to help herself get in and out of bed. Interview on 9/17/24 at 9:30 a.m. with registered nurse D regarding the U-shaped bar revealed the occupational therapist (OT) had completed an assessment for the use of it. Review of resident 3's care record revealed: *An admission date of 3/4/24. *Her diagnoses included post femoral fracture, depression, atrial fibrillation, and anxiety. *There was no physician's order for the use of the U-shaped assist bar on her bed. *There was no documentation on her service plan for the use of the U-shaped assist bar on her bed. *The 7/2/24 Resident Evaluation Instrument Side Rail assessment indicated it had been completed. -On 3/26/24 the U-shaped bar had been placed on her bed. Review of the following occupational therapist note evaluations regarding resident 3 revealed on: *3/19/24: "A bed handle was recommended. Her	S 837	POC S 837: Affected Resident: A doctor's order for a bed transfer device was received for resident 3. Resident 3's care plan was updated to document the necessity of a bed transfer device. Fabric of resident 3's bed transfer device was corrected. Potential Affected Resident(s): All residents who need a bed transfer device will have it documented in their service plan. A doctor's order will be requested annually for all residents who need a bed transfer device. Care records of all residents who need a bed transfer device were reviewed to ensure the service plan indicate the use of a bed transfer device. Service plans were updated as necessary. A physician's order was received for each resident that uses a bed transfer device. All bed transfer devices were checked and adjusted to assure safety...fabric corrected etc.	10/14/24

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S 837	Continued From page 27 son was contacted with this recommendation." *3/21/24: "The bed handle was brought to her room to demonstrate how it works. She would like to try it but will talk with her son first." *3/26/24: "Pt [resident] did purchase the bed handle so this OT installed it on her bed." Interview on 9/18/24 at 9:45 a.m. with administrator A and certified nurse practitioner K regarding the assist bar for resident 3's bed revealed: *The OT assessed resident 3 and then sent a recommendation to them for the use of the assist bar for her bed. *There was not a physician's order for her to use the assist bar for her bed. *Her service plan had not been updated for the use of the assist bar for her bed. Review of the provider's undated No Restraint policy revealed: *"To create a safe and supportive environment where physical, mechanical, and chemical restraints are not used under any circumstances, promoting dignity, respect, and autonomy for all individuals in care." Review of the provider's 3/6/24 Quality of Life policy revealed: *"[Name of facility] provides care and an environment that contributes to the resident's quality of life." *"[Name of facility] strives to provide: -3. Freedom from physical or chemical restraints imposed for purposes of discipline or convenience."	S 837	S 837 cont: Measures/Systemic Changes: No Restraint Policy reviewed and remains current. All nursing staff will review No Restraint Policy. Quality of Life Policy reviewed and remains current. All nursing staff will review Quality of Life Policy. Monitoring: Care records will be audited monthly for 6 months for proper bed transfer device documentation on service plans and for physician's order for bed canes. Two bed transfer devices will be checked monthly for 6 months to ensure safety of device. The DON will be responsible for compliance. Results of the monitoring will be reported to the QA commmittee monthly with ongoing frequency and duration to be determined through analysis and review of results.	

South Dakota Department of Health

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	10720	A. BUILDING: _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH PRAIRIE RETIREMENT HOME	19129 PRAIRIE HILLS ROAD BELLE FOURCHE, SD 57717

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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 from 9/17/24 through 9/19/24. High Prairie Retirement Home was found not in compliance with the following requirements: S201 and S450. 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 9/17/24 through 9/19/24. Area surveyed included elopement. High Prairie Retirement Home was found not in compliance with the following requirements: S030.	S 000	Supervisor A has put into place training for all employees to complete in the annual Training about reporting abuse incident, accidents, and elopement, Supervisor A or Nurse, Administrator will follow up within 24 hours to the Department of Health of any incident, accident, or abuse and elopement. Also has trained all staff what steps to take to keep our residents safe and focused so there mind wont be on leaving the facility	
S 030	44:70:01:07 Reports To The Department Each facility shall report 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 other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas.	S 030		

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

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S 030	Continued From page 1 The facility shall conduct an internal investigation for 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 an elopement for one of one sampled resident 1 (left the facility without staff knowledge) to the South Dakota Department of Health (SD DOH). Findings include: 1. Review of resident 1's care record revealed: *His admission date was 2/23/09. *His Mini-Mental Status Examination score was 25 which indicted he had minimal cognitive impairment. *His diagnoses included traumatic brain injury, dementia, Parkinson's with tremors, and alcoholism. *An undated note to his primary doctor: "{Resident 1} has been very confused lately on Tuesday we found him walking out on the road almost into oncoming traffic." *A 7/25/24 note to another facility: "he been known to wander outside and was caught walking out to the interstate part in [local town] on a hot day." Interview on 9/19/24 at 10:22 a.m. with facility supervisor B revealed he: *Was driving back from another town around noon on July 25th when he saw resident 1 at the stop sign when he turned to go to the assisted	S 030		