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
	11035	A. BUILDING: ______ B. WING ______	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VICTORIAN ASSISTED LIVING	1321 COLUMBUS ST. RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 6/10/24 through 6/11/24. Areas surveyed included resident neglect, misappropriation of resident property, and quality of life. The Victorian Assisted Living was found not in compliance with the following requirements: S337, S405, and S846.	S 000		7/26/2024
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on a South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to appropriately monitor and document the condition of one of one sampled resident (1) after two of two falls. Findings include: 1. Review of the provider's 4/16/24 SD DOH FRI revealed: *Resident 1 was found on the floor of her room on 4/15/24 at about 8:50 p.m. -An ambulance was called due to "possible head trauma" from that fall. *The resident refused transport to the local hospital for further assessment of her injury and remained at the facility after the fall. *Staff found the resident in bed and not arousable	S 337	S337 1.All residents have the potential to be affected by this deficiency. 2.DON B is no longer employed by the facility 3.All staff received education at staff meeting held on 6/25/2024 for the following a. Fall Policy including reporting requirements and mandatory notifications b. Updated Post Fall Monitoring Tool and required monitoring of all unwitnessed falls and falls in which an injury to the head occurred. c. Documentation expectations following falls. 4. Fall Tracking Log has been implemented where all falls will be logged and tracked by DON or designee for completeness and accuracy. 5. Audit of Fall Tracking Log will be completed by DON or designee weekly x 4 weeks, then monthly x 3 months and monthly thereafter until substantial compliance is met. 5. The results of these audits will be brought to the QA members monthly for review and advisement until substantial compliance is met for 3 consecutive months.	7/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Maciejewski (signed) Lisa Maciejewski
TITLE: Executive Director
(X6) DATE: 6/25/2024

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S 337	Continued From page 1 on 4/16/24 at 5:25 a.m. -She was transported by ambulance to the local hospital and diagnosed with a brain bleed. *The conclusionary summary statement on the FRI included a plan to develop and implement a new post-fall monitoring tool for unwitnessed falls and falls in which an injury to the head occurred. Review of resident 1's electronic medical record (EMR) revealed: *Director of nursing (DON) B's progress note after resident 1's 4/15/24 fall indicated: -"EMT [emergency medical technician] stated to Med Aide [unlicensed medication aide that resident [resident 1] refused to go to the hospital and with their assessment EMT'S said she'd be OK and helped her to her chair." -"Med Aide states that resident's pain is at a 3. Med Aide administered Tylenol and gave resident an ice pack to apply to right forehead area. I asked Med Aide to follow up with protocol Vitals and to monitor resident with any changes." *Resident 1's 4/15/24 post-fall vital signs and pain level monitoring sheet revealed an initial set of vital signs and a pain level score. -There was no other documented post-fall monitoring of resident 1 after she fell. 2. Continued review of resident 1's EMR revealed: *A 5/11/24 incident report indicated staff responded to the resident's call light at 2:55 a.m. and found her on the floor between her recliner and bed. -"She [resident1] said she 'thumped' her head'..." -No bruising, bumps, cuts, or bleeding were noted to the left side of her forehead that she had hit. *There was no indication on that report DON B or any other management staff were notified of the fall.	S 337		

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S 337	Continued From page 2 *The resident's contact person and her medical provider were notified of the fall on 5/13/24. *DON B signed the incident report as having "reviewed" it but there was no indication of what date that had occurred and no fall-related follow-up was noted on that report. *There were no progress notes in the resident's EMR regarding the 5/11/24 fall and no documentation of any post-fall monitoring of the resident had occurred. Interview on 6/11/24 at 9:00 a.m. with administrator A and DON B regarding the 4/16/24 FRI follow-up plan and resident 1's 5/11/24 fall follow-up revealed: *The plan for the development of a post-fall monitoring tool for unwitnessed falls and falls that included an injury to the head referenced in the 4/16/24 FRI was not completed. *Since resident 1's 4/15/24 fall she had a second head injury-related fall on 5/11/24. -There was no documentation to support she was monitored by staff for potential post-fall complications after that fall. *Administrator A expected "handoff" communication between shifts that would have included a report of resident falls and discussion of post-fall monitoring documentation expectations related to that fall. *DON B was responsible for having ensured the fall protocol was followed. Review of the provider's undated Fall policy revealed: *"6. The Administrator instructs caregivers to provide appropriate care and frequent resident checks. Any change in status is reported to the Administrator". -There was no mention of DON B's role and responsibilities in relationship to resident falls.	S 337		

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S 337	Continued From page 3 Review of the Incident Report form revealed it included instruction for the completed form to have been given to DON B at the end of the shift it was completed on.	S 337		
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Prog The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to develop and revise individual resident care plans to reflect the current needs of two of two sampled residents (1 and 2). Findings include: 1. Review of the provider's 4/16/24 submitted SD DOH FRI revealed: *Resident 1 was found on the floor near her bed at 8:50 p.m. on 4/15/24. -She returned to her bed from the bathroom, lost her balance and fell. *The conclusionary summary statement of the provider's fall investigation included a plan to update the resident's care plan for falls. Observation and interview on 6/10/24 at 12:30 p.m. with resident 1 in her room revealed:	S 405	S405 1.All residents have the potential to be affected by this deficiency. 2.DON B is no longer employed by the facility 3.Administrator or Licensed Healthcare designee has reviewed, updated and individualized resident 1 and 2's service plan to ensure plan is a resident-centered service plan that provides services that are based on her individual needs, abilities, and preferences. 4.Administrator has reviewed all current resident's service plans to ensure they are accurate and individualized. 5.All staff have been educated on where to view residents' service plans. 6.All staff have received education at staff meeting held on 6/25/2024 on the following: a. Proper documentation expectations b. Reporting process for and Change Of Condition c. Ongoing Resident Appraisal Policy 7.Administrator or Licensed Healthcare Staff Designee will audit 5 residents service plans to ensure they address the medical, physical, mental and emotional needs of the resident as well as individualization. Audits will be completed weekly x 4 weeks, monthly X 3 months, then monthly thereafter until substantial compliance is met. 8.The results of these audits will be brought to the QA members monthly for review and advisement until substantial compliance is met for 3 consecutive months.	7/26/2024

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*She was seated in her recliner chair with her wheeled walker nearby and had a call alert pendant around her neck.
*Her room was uncluttered.
*She did not know why she fell on 4/15/24 but stated she was cautious to avoid falls.
*Her upper extremities tremored, and she denied any recent changes in her physical strength.
*She used the bathroom multiple times during the night and wore incontinence pads.
*She kept a light on in the bathroom and her window blind partially opened to see better at night.
-She walked to and from her bathroom with her walker at night without staff assistance.
*She slept in a single-sized bed.
-Her box spring was removed from her bed since her fall leaving only a mattress on the bedframe.
--That lowered her bed and allowed her to more easily get in and out of her bed.

Review of resident 1's current care plan revealed it was updated with the following fall interventions since 4/15/24:
*Repositioning bar to the right side of the resident's bed to assist her in and out of bed.
*Call for assistance.
*Adequate lighting.
*Proper footwear.
*Clutter-free environment.

Interview on 6/10/24 at 3:00 p.m. with administrator A and director of nursing (DON) B regarding resident 1's care plan revealed:
*They were not aware there was no repositioning bar on the resident's bed.
*They were not aware the resident's box spring was removed.
*Agreed the fall interventions identified in the resident's care plan were vague and not

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individualized based on resident 1's needs and preferences.

Review of the provider's undated Fall policy revealed " 8. The service plan of the resident should be updated to reflect fall risk and any needed
interventions to help minimize further fall risk."

2. Review of resident 2's electronic medical record revealed:
*Her admission date was 8/30/21.
*Her diagnoses included spinal stenosis, anxiety, gastroesophageal reflux, and hypertension.
-She was administered a daily anti-anxiety medication.

Review of resident 2's current care plan revealed:
*Mood problem interventions were last revised on 5/30/23 and included:
-"Taking medications.
-Reporting mood changes.
-Encouraging social events.
-Encouraging expression of feelings or concerns to caregivers and/or family."
*Activity interventions were last revised on 12/6/23 and included:
-"Flexible with daily routine.
-Enjoys bingo, musical guests, and some informational movies."

Interview on 6/10/24 at 1:30 p.m. with activities director E regarding resident 2 revealed:
*The resident had not been attending bingo or informational movies and had rarely attended musical programming.
-It had been "too long" since she had assessed the resident's activity interests. "I need to do that."
*No in-room or one-on-one activity programming was provided for the resident.

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S 405	Continued From page 6	S 405		

Interview on 6/10/24 at 2:15 p.m. with DON B regarding resident 2 revealed:
*She spent most of her time alone in her room.
*DON B's conversations with the resident were often long in duration and included various complaints.
*The resident made her own choices and was mostly independent with her care.
*She identified with her German nationality.

Observation and interview on 6/11/24 at 8:15 a.m. with resident 2 in her room revealed:
*She preferred to be alone in her room most of the time.
-She was not a "people person" and was more comfortable by herself than with others.
*She ate most meals in her room.
*Her hearing and vision were diminished.
*She spoke with a foreign accent that she felt was difficult for some people to understand.
*There was a television in her room, and she liked to read.
*The drawers on her dresser and her closet doors each had locks on them.
-That was to deter unauthorized removal of her personal possessions.
*She was comfortable talking with DON B and BOM D about her grievances.

Interview on 6/10/24 at 2:45 p.m. and on 6/11/24 at 9:30 a.m. with administrator A regarding resident 2 revealed:
*Her relationship with the resident was strained because the resident associated her with bill payments and finances.
-She felt some staff related better to the resident than others and the resident was more inclined to do things for them than she was for other staff.
*The resident had a niece who lived locally but

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S 405	Continued From page 7 had limited contact with the resident. *She thought the resident may have experienced some historical trauma. *The resident had been unwilling to allow her mental health provider to make changes to her mood-altering medications and terminated that relationship. *The resident had a history of voicing grievances. Interview on 6/11/24 at 9:30 a.m. with administrator A and DON B regarding resident 2's care plan revealed: *It was not individualized to reflect the resident's preferences, strengths, limitations, and history referred to above. *There were no interventions that guided caregivers on how best to interact and work with her. *No behavioral plan was developed with the resident in reference to managing her grievances. Review of the provider's undated Service Plan policy revealed "A resident-centered service plan is created and maintained for every resident. The purpose of the service plan is to provide a centralized coordination of the services that will be provided to each resident, based on his or her individual needs, abilities, and preferences."	S 405		
S 846	44:70:09:10(1-4) Grievances The grievance process must include the facility's efforts to resolve the grievance and documentation of: (1) The grievance; (2) The names of the persons involved; (3) The disposition of the matter; and (4) The date of disposition.	S 846	S846 1.All residents have the potential to be affected by this deficiency. 2.DON B is no longer employed by the facility 3.All staff have received education at staff meeting held on 6/25/2024 for the following: Continued below	7/26/2024

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S 846	Continued From page 8 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to ensure their grievance process was implemented for the investigation, resolution, and follow-up of documented grievances for one of one sampled resident (2). Findings include: 1. Review of resident 2's electronic medical record revealed: *Her admission date was 8/30/21. *Her diagnoses included spinal stenosis, anxiety, gastroesophageal reflux, and hypertension. -She was administered a daily anti-anxiety medication. Interview on 6/10/24 at 2:15 p.m. with director of nursing (DON) B regarding resident 2 revealed: *Her conversations with the resident were often long in duration and included some complaints. *The resident shared multiple grievances (complaints) with DON B within the past month. -She gave the resident a grievance form on which to document those grievances. *On or about 5/30/24 resident 2 returned her completed grievance form to DON B. *DON B forwarded that form to business office manager (BOM) D whose office was located in another building. Observation and interview on 6/11/24 at 8:15 a.m. with resident 2 in her room revealed: *She was comfortable talking with DON B and BOM D about grievances. -On or about 5/30/24 she gave DON B a grievance form she completed. Interview on 6/10/24 at 2:45 p.m. and on 6/11/24	S 846	a. Grievance policy and documentation requirements to include stated grievance, name of persons involved, disposition of the matter and date of disposition. 3. Grievance Tracking Log has been implemented and all grievances will be entered and tracked by the Administrator to ensure accuracy and compliance to policy. 4. Audit of Grievance Tracking Log will be completed by DON or designee weekly x 4 weeks, then monthly x 3 months and monthly thereafter until substantial compliance is met. 5. The results of these audits will be brought to the QA members monthly for review and advisement until substantial compliance is met for 3 consecutive months	

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S 846	Continued From page 9	S 846		

at 9:30 a.m. with administrator A regarding resident 2 revealed:
*Her relationship with the resident was strained because the resident associated her with bill payments and finances.
-She felt some staff related better to the resident than others and the resident was more inclined to do things for them than she was for other staff.
*She thought the resident may have experienced some historical trauma.
*The resident had been unwilling to allow her mental health provider to make changes to her mood-altering medications so that relationship was terminated.
-The resident also had terminated her relationship with the provider's ombudsperson (resident advocate) and had limited contact with her niece.
*The resident had a history of voicing grievances but not all of them warranted documentation and investigation.
-Some were repeated grievances that occurred too long ago to investigate.
-Some were not detailed enough to investigate.
-Some included minor things such as a missing Jolly Rancher candy that had not warranted an investigation.
*Administrator A was not aware resident 2 had completed and turned a grievance form in to DON B at the end of May 2024.
-It was not known if the grievance was followed-up on.

Interview on 6/11/24 at 9:30 a.m. with administrator A and DON B regarding resident 2's May 2024 grievance form revealed:
*The form was e-mailed to administrator A by BOM D that morning.
-There was no documentation to support an investigation of resident 2's grievances was completed and no indication staff had

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S 846	Continued From page 10 communicated with the resident the outcome of any actions taken regarding those grievances. *The grievance process was not followed. -Administrator A would have expected DON B to have documented a written investigation of the grievances resident 2 had identified on the May 2024 form. -DON B was not aware it was her responsibility to have initiated and completed that process. -DON B's hire date was 4/5/24. Review of the undated Grievance Procedure policy revealed: *"2. This complaint needs to be submitted to the Resident Care Manager [DON B] Office at the address above, within 5 days after its filing. *3. The Resident Care Manager, or his/her designee shall conduct such investigation of a complaint as may be appropriate to determine its validity..." *"4. The Resident Car Manager shall issue a written decision determining the validity of the complaint no later than 30 days after its filing."	S 846		

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{S 000}	Compliance Statement 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 8/1/24 for deficiencies cited on 6/11/24. All deficiencies have been corrected, and no new noncompliance was found. The Victorian Assisted Living is in compliance with all regulations surveyed.	{S 000}		

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