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
	66221	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - ST MARTIN VILLAGE	4811 ST MARTIN DR RAPID CITY, SD 57702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 3/24/25 through 3/26/25. Good Samaritan - St. Martin Village was not in compliance with the following requirements: S201, S320, S330, S331, S337, S503, S506, S630, S632, and S650.	S 000		
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 record review and interview, the provider failed to conduct fire drills as required for the period from April 2024 through March 2025 (seven drills were held without evacuation). Findings include: 1. Record review revealed fire drill log sheets showed fire drills were held from April 2024 through March 2025 as follows: *6/25/24 at 8:30 a.m. *6/28/24 at 7:20 p.m. *9/23/24 at 11:05 a.m. *9/27/24 at 8:45 p.m. (silent drill) *11/15/24 at 11:50 a.m.	S 201	Unable to correct prior deficient practice. All residents are at risk when fire drills are not conducted per policy and when the flow tests are not completed on the sprinkler system per policy. Fire drill and flow test for the sprinkler system were added into our TELS (maintenance work request system) to be checked off by a maintenance employee as they present as a task to be completed. Ancillary manager or designee will audit completion of fire drills and quarterly flow tests weekly x3, every other week x3, and monthly x3. Ancillary manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Ancillary Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	4.25.25

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S 201	Continued From page 1 *12/30/24 at 7:30 p.m. *3/26/25 at 9:50 a.m. (during survey inspection) Fire drills must be conducted monthly and the fire alarm must be sounded each month. 2. During the above observed 3/26/25 fire drill, one resident was in the lounge watching television and did not react to the fire alarm until staff alerted her that there was a fire drill in progress. 3. Interview on 3/26/25 at 10:00 a.m. with the maintenance supervisor confirmed those findings. He stated the provider would conduct fire drills at the end of the month in the third month of the quarter. He stated the provider would perform fire drills as "defend in place" (to rely on trained staff actions and the building's fire protection features to protect occupants without evacuating) similar to a nursing home. A written approval from the Department of Health to conduct fire drills as "defend in place" for the assisted living occupancy was not available. B. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in May 2024). Findings include: 1. Record review revealed the required quarterly flow tests had not been performed in the past year. Quarterly flow tests had been performed on 2/21/24, 8/22/24, and 12/5/24. A quarterly flow test had not been performed in May 2024. Interview with maintenance supervisor at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of	S 201		

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S 201	Continued From page 2 death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	S 201		
S 320	44:70:08 Prevention And Control Of Pneumonia Each facility shall arrange for an immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage a resident to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, policy review, and interview, the provider failed to ensure one of three (1) sampled residents had received the pneumococcal vaccine, or received or declined the vaccination at a different location within 14 days of admission. Findings include: 1. Review of resident 1's care record revealed the following: *Resident 1's admission date was 4/17/24. *Review of resident 1's electronic medical record revealed: -There was no documentation that indicated resident 1 had received or declined the pneumococcal vaccine, at the facility or a different location within 14 days of her admission date. *Resident 1 had received the pneumococcal vaccination on 11/25/24, 222 days from her date of admission.	S 320	Unable to correct prior deficient practice. All residents are at risk when vaccines are not offered or administrated within 14 days of admission. Education will be provided by the Senior Living Manager or designee to licensed nurses to ensure that all new admissions have been offered required vaccines within 14 days of admission. Senior Living Manager or designee will audit completion of new admission vaccinations for compliance weekly x3, every other week x3 and monthly x3. Senior Living Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Senior Living Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	5.5.25

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S 320	Continued From page 3 Review of the provider's 3/19/25 State-Specific Senior Living Information policy revealed: *"Prevention and control of pneumonia -a. Each facility shall arrange for an immunization for pneumococcal disease. The vaccination may be given by the primary provider, or home health/pharmacy partners who are able to bill the resident's insurance. -b. If immunization is lacking and the resident's provider recommends immunization, the facility shall encourage [the]resident to obtain an immunization for pneumococcal pneumonia within 14 days of [the resident's] admission. -c. Documentation of the vaccination or refusal must be recorded in the resident's care record." Interview on 3/26/25 at 8:42 a.m. with registered nurse B regarding the pneumococcal vaccination of resident 1 revealed: *She confirmed there was no documentation to support resident 1 had received or declined the pneumococcal vaccine, or received or declined the vaccination at a different location within 14 days of admission. *The admission nurse was responsible for ensuring the resident's vaccinations were offered, given, or refused, and documented in the resident's care record. *She agreed the provider's policy was not followed. Interview on 3/26/25 at 10:12 a.m. with Senior Living Manager A regarding the pneumococcal vaccinations for resident 1 revealed he acknowledged the vaccination was not given within 14 days of admission, but did not offer additional information or feedback.	S 320		

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S 330	Continued From page 4	S 330		
S 330	44:70:04:10 Tuberculin Screening... Requirements Each facility shall develop criteria to screen healthcare personnel and residents for Mycobacterium tuberculosis (TB) based on the Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. Each facility shall establish policies and procedures for conducting TB risk assessment that include the key components of responsibility, surveillance, and containment. The frequency of repeat screening depends upon annual facility risk assessment results. Any resident identified as asymptomatic upon admission as short stay or anticipated stay of thirty days or less is not required to have a tuberculin skin test or a TB blood assay test. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview the provider failed to ensure the annual (2024) tuberculosis (TB) facility assessment was completed. Findings include: 1. Review of the provider's most recent annual TB risk assessment revealed: *The assessment was completed on 12/2/24. -The assessment indicated the state TB data used for the assessment was from January 2023 through December 2023. *There was no 2025 TB assessment that included the 2024 state TB data. Interview on 3/26/25 at 8:32 a.m. with registered nurse B regarding the yearly TB facility assessment revealed she:	S 330	Unable to correct prior deficient practice. Tuberculin assessment has been completed and is current. All residents are at potential risk for deficient practice due to noncompliance with the yearly Tuberculin assessment. Education will be provided by the Senior Living Manager or designee to all licensed nurses regarding the expectation of yearly tuberculin assessment completion. The Senior Living Manager or designee will audit tuberculin assessment for compliance weekly x3, every other week x3 and monthly x3. Senior Living Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Senior Living Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25

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S 330	Continued From page 5 *Had completed the facility TB assessment on 12/2/24 and used the state's published TB data for 2023. *Thought since the assessment was completed in 2024 it covered the requirement of being completed annually. *Was not aware the 2024 assessment should have been completed in 2025 when the number of 2024 TB cases for the state were made available. -The state TB cases for 2024 were published on the South Dakota Department of Health website on 2/4/25. Interview on 3/26/25 at 10:11 a.m. with Senior Living Manager A regarding the annual TB facility assessment revealed he acknowledged the non-compliance but did not offer additional information or feedback.	S 330	Unable to correct prior deficient practices. Resident 1 had a Quantiferon Gold test completed with negative results. All residents are at potential risk for deficient practice due to noncompliance of tuberculin testing within 14 days of admission. Education will be provided by the Senior Living Manager or designee to all licensed nurses to ensure all new admissions have tuberculin testing completed within 14 days of admission. The Senior Living Manager or designee will audit all new admissions for compliance weekly x3, every other week x3, and monthly x3. Senior Living Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Senior Living Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests	S 331		5.5.25

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S 331	Continued From page 6 are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to ensure one of three sampled resident (1) received a tuberculin (TB) baseline screening and TB skin test within twenty-one days of admission. Findings include: 1. Review of resident 1's care record revealed: *She was admitted on 4/17/24. *There was no documentation of a TB skin test. Interview on 3/26/25 at 8:42 a.m. with registered nurse B regarding TB testing of newly admitted residents revealed: *The nurse who completed the resident's admission was to complete a TB skin test. *She was not able to locate any TB skin test results for resident 1.	S 331		

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S 331	Continued From page 7 Interview on 3/26/25 at 10:15 a.m. with Senior Living Manager A revealed he acknowledged the [event] but did not offer additional information or feedback. Review of the provider's 3/19/25 State-Specific Senior Living Information policy revealed: *"Tuberculin screening and testing requirements." -"The frequency of repeat screening shall depend upon annual facility risk assessment results." --"Tuberculin screening requirements for personnel and residents include: Initial individual TB risk assessment documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 21 days of employment or [a resident's] admission to a facility."	S 331	Unable to correct prior deficient practices. Resident 3 has switched pharmacies and resident 2 has had the fluid restriction discontinued. All residents are at potential risk for deficient practice due to non-compliance with availability of medications and fluid restrictions. Education will be provided by the Nurse Manager or designee to all nursing staff regarding the availability of medications. Education will be provided by the Senior Living Manager to all licensed nurses related to fluid restrictions. Nurse Manager or designee will audit any unavailable medications to ensure that we have the medications ordered and a replacement can be provided. Senior Living Manager or designee will audit any new fluid restrictions for compliance weekly x3, every other week x3 and monthly x3. Nurse Manager or designee and Senior Living Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Nurse Manager or designee and Senior Living Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	
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 record review, interview, and policy review, the provider failed to: *Ensure physician prescribed medications were available for two of two sampled residents (1 and 3) on two of two documented occasions. *Monitor and document physician prescribed fluid restrictions for one of one sampled resident (2). Findings include:	S 337		5.5.25

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S 337	Continued From page 8 1. Review of resident 1's care record revealed: *Her admission date was 4/17/24. *Her 4/17/24 Brief Interview of Mental Status (BIMS) assessment score was a 12, which indicated she had moderate cognitive impairment. *Her diagnoses included: Type 2 diabetes, obesity, hypertension (high blood pressure), and mood disorder. *Her 12/12/24 self-administration of medication assessment revealed she was able to self-administer Basaglar insulin, Ozempic (injectable medication for blood sugar regulation), and complete her own blood sugar checks with supervision. *Her medication administration record indicated on 10/10/24 her Basaglar was not administered as it was not available. *Her nurse progress notes indicated on 10/11/24 a "partial dose of Basalgar was administered as there was [were] no refills for that medication available." -On 11/7/24 the pharmacy her medications were ordered from was changed. 2. Review of resident 3's care record revealed: *Her admission date was 9/10/21. *Her 1/30/25 BIMS assessment score was a 10, which indicated she had moderate cognitive impairment. *Her diagnoses included: polymyalgia rhematica (a disorder that causes shoulder/hip pain and stiffness), heart disease, chronic kidney disease, glaucoma (eye condition that may cause vision loss), and amnesia (memory loss). *Her nurse progress notes indicated that: -On 1/6/25 a phone call was "placed to [pharmacy] r/t [related to] getting Prednisone [steroid] and Eliquis [blood thinner] sent to facility." "pharmacy tech will have the medications	S 337		

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S 337	Continued From page 9	S 337		

sent over today. Awaiting delivery."
-On 2/24/25 at 11:20 a.m. a phone call was placed to the pharmacy about resident 3's medication refills and it was "reported that someone with [pharmacy] had discharged [resident 3] from Med [medication] services but wasn't sure who and [she] will reactivate meds [medication orders] and have medications sent to ALF [assisted living facility] today."
-On 2/24/25 a "call back" from the pharmacy that the provider would "no longer [be] refilling [resident 3's] medications d/t [due to] no contract with [facility] as of last week".
-On 2/27/25 signed and approved orders were received from resident 3's primary care provider and faxed to the new pharmacy to be filled.
*Her medication administration record revealed the following medications were not administered as they were not available:
-On 2/5/25, one dose of Eliquis.
-On 2/6/25, two doses of Eliquis.
-On 2/7/25, one dose of Eliquis.
-On 2/22/25 one dose of Trulicity (for diabetes).
-On 3/8/2025 one dose of prednisone.
-On 3/15/25 one dose of Trulicity.
-From 3/19/25 through 3/25/25, seven doses Januvia (for diabetes).

3. Interview on 3/26/25 at 8:25 a.m. with registered nurse (RN) B regarding physician ordered medications not available to administer to residents revealed:
*Regarding resident 1's 10/10/24 documentation that medication was not available "when she moved in she was self-administering all medications." "We need to have [pharmacy] get these."
*The provider's policy was for the physician to be notified "when 2 doses [of medication] were not administered".

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S 337	Continued From page 10	S 337		

*Regarding resident 3:
-Resident 3 had changed pharmacies, as the provider was having difficulty getting medications from the original pharmacy.
-She stated, there were instances when the pharmacy and/or the facility staff had contacted the resident's physician and the physician did not refill the prescription or the prescription needed to be renewed.
-She stated, "[Unavailable medications] was a pharmacy issue and has since been fixed".

4. Review of the provider's 9/17/24 Medication Administration policy revealed:
*"Medications will be administered to the resident according to the "six rights" (right medication, right dose, right resident, right route, right time and right documentation)."
*"If a medication is not available for 24 hours, the provider [resident's pysician] must be notified that the medication is not available and must give direction for how to proceed."

5. Observation on 3/24/25 at 3:58 p.m. of resident 2 revealed he was in the activity area, playing cards with an unidentified resident, and drinking a light beer with a straw.

6. Review of resident 2's care record revealed:
*He was admitted on 3/18/25.
*His Brief Interview of Mental Status assessment score was a 15, which indicated his cognition was intact.
*His diagnoses included: chronic diastolic heart failure (condition that causes reduced blood flow from the heart to the body), anxiety, depression, Lupus (an autoimmune disease which can include kidney problems).
*His physician orders revealed on 3/18/25 he was to have fluid restrictions (a prescribed therapeutic

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S 337	Continued From page 11	S 337		

diet that limits fluids to manage specific medical conditions, such as fluid retention or electrolyte imbalances) of 2000 cc (cubic centimeter) in 24 hours, that was to be given as follows:
-"Nursing needs for medication passes - 560 cc/24 hrs [hours]". "Day: 200 cc, Eve: 200, NOC [night]: 160cc)."
-"Dietary distribution Plan_1400 cc/24 hrs". "Breakfast 480cc (8oz [ounces]+8oz), Lunch 480cc (8oz+8oz) NO ICE CREAM, SOUP, JELLO, POPSICLES every shift for CHF (congestive heart failure)".
*Review of his registered dietitian's progress notes revealed:
-He was on a 2000 ml (milliliter) fluid restriction, "no issue with intakes noted", and "no labs available".
*His service plan did not indicate that he was on fluid restrictions.
*There was no documentation of his fluid intake being monitored in his care record.

7. Interview on 3/25/24 at 3:28 p.m. with dietary manager G revealed he was not aware of what a therapeutic diet with fluid restrictions was.

8. Interview on 3/26/25 at 8:29 a.m. with RN B regarding documentation of a residents' fluid intake when on a fluid restriction revealed:
*They had no monitoring or documentation process for residents' fluid intake.
-She indicated the physician's order "just shows med aides [medication aides/unlicensed assistive personnel] how much fluid they can give at med [medication] pass".
*She stated there was no way to know how much fluid he drank when he was in his room.

9. Review of the provider's 9/11/24 Diet Orders - Food and Nutrition policy revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66221	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - ST MARTIN VILLAGE	4811 ST MARTIN DR RAPID CITY, SD 57702

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S 337	Continued From page 12 *"Definitions -Therapeutic diet - A diet intervention ordered by a healthcare practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status; to eliminate, decrease or increase certain substances in the diet (e.g., sodium, potassium)". 10. Interview on 3/26/25 at 10:10 a.m. with Senior Living Director A regarding the availability of medications and physician ordered fluid restrictions revealed he acknowledged the non-compliance but did not offer additional information or feedback.	S 337		
S 503	44:70:06:16(1-3) Person In Charge Of Dietary Services The person in charge of dietary services shall possess a current certificate from: (1) A ServSafe Food Protection Course; (2) The Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association; or (3) Equivalent training as determined by the department. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and policy review, the provider failed to ensure the dietary manager had completed and possessed a current ServSafe Food Protection Program certificate. Findings include:	S 503	Unable to correct prior deficient practices. Dietary Manager will have their Serv Safe certification by May 5, 2025. All residents are at potential risk for deficient practice due to noncompliance of obtaining a Serv Safe. Education will be provided by the Senior Living Manager or designee to the dietary manager in regards to the policy of having a Serv Safe certification. Senior Living Manager or designee will audit Serv Safe certification for compliance weekly x3, every other week x3 and monthly x3. Senior Living Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Senior Living Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25

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	66221	A. BUILDING: _____ B. WING _____	03/26/2025

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S 503	Continued From page 13 1. Interview on 3/25/24 at 3:28 p.m. with dietary manager G regarding employee ServSafe training revealed he: *Was in charge of the dietary department for the assisted living center. *Was hired "about four months ago". *Was not ServSafe Food Protection Program certified. Interview on 3/26/25 at 11:10 a.m. with Senior Living Manager A revealed he: *Was aware DM G was not ServSafe Food Protection Program certified. *Thought DM G was scheduled to start the ServSafe Food Protection Program course "sometime in April".	S 503	Unable to correct prior deficient practices. All employees will complete past due learning to ensure they are up to date by May 5, 2025. All residents are at potential risk by staff not completing their education. Dietary Manager was educated by the Senior Living Manager or designee that all mandatory education must be completed annually. Dietary manager or designee will audit completion of required learning weekly x3, every other week x3 and monthly x3. Dietary manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Dietary Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements.	S 506		

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	66221	A. BUILDING: _____ B. WING _____	03/26/2025

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S 506	Continued From page 14 This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel training records, interview, and policy review, the provider failed to ensure: *Three of three dietary employees (D, E, and F) had received ongoing dietary in-service education on the required topic of nutrition and hydration. *One of three sampled dietary employees (F) had received ongoing dietary in-service education on the following topics: food safety, food handling and preparation techniques, food-borne illness, serving and distribution of food procedures, time and temperature controls for food preparation and service, and sanitation requirements. Findings include: 1. Dietary aide (DA) D was hired on 8/23/22. *Her last documented education completed for nutrition and hydration was on 11/3/23. 2. Dietary aide (DA) E was hired on 4/12/22. *Her last documented education completed for nutrition and hydration was on 11/4/23. 3. Cook F was hired on 1/16/24. *Her last documented education completed for nutrition and hydration was on 1/19/24. *Her last documented education completed for food safety, food handling and preparation techniques, food-borne illness, serving and distribution of food procedures, time and temperature controls for food preparation and service, and sanitation requirements was on 1/17/24. 4. Interview on 3/25/25 at 1:35 p.m. with dietary	S 506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66221	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 506	Continued From page 15 manager G regarding required ongoing education for dietary employees revealed: *He was aware there was a requirement for initial and on-going education for all dietary employees. *The dietary in-service education was an electronic system and was assigned by the provider's corporate office. *He confirmed there was no documentation to support the above dietary in-service education had been assigned or completed. *He was not sure if he was responsible for following-up with each employee to ensure their education was completed. 5. Interview on 3/26/25 at 10:09 a.m. with Senior Living Manager A regarding ongoing dietary education revealed he acknowledged the non-compliance but did not offer additional information or feedback." 6. Review of the provider's 9/11/24 Diet Orders - Food and Nutrition policy revealed: *"Food and nutrition employees receive training during orientation, as well as ongoing in-service education, on therapeutic, texture-modified food preparation and portion control."	S 506	Unable to correct prior deficient practices All residents are at potential risk if room and refrigerator temperatures are not documented per policy. Education will be provided by the Nurse Manager or designee to all nursing staff in regards to ensuring the temperature of the medication room and refrigerator are documented per policy. Nurse Manager or designee will audit room and refrigerator temperatures for compliance weekly x3, every other week x3 and monthly x3. Nurse Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Nurse Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	
S 630	44:70:07:04 Storage And Labeling Of Medications All medications must be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be	S 630		5.5.25

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S 630	Continued From page 16 maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight degrees centigrade. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *One of two observed medication refrigerators' temperatures were maintained at a consistent and acceptable temperature and documented. *Two of two observed medication storage rooms' temperatures were maintained at a consistent and acceptable temperature and documented. Findings include: 1. Review of the Medication Room and Refrigerator Temperature Log and interview on 3/25/25 at 3:05 p.m. with unlicensed assistive personnel (UAP) C in the Mathew Mark medication room revealed: *The Medication Room and Refrigerator Temperature Log posted on the medication refrigerator included an area to document the month, year, and a daily refrigerator and room temperatures, action taken if temperatures were out of range, and employee initials. -There was no month or year documented on the form. -There was no refrigerator temperature documented from the first through the fourth, and the 16th through the 23rd. -There was no room temperature documented from the first through the fourth, and the 10th through the 23rd. --There was a squiggly line drawn through the room temperature column from the 10th through the 31st, and in the Action Taken column from the 1st through the 31st.	S 630		

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	66221	A. BUILDING: _____ B. WING _____	03/26/2025

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S 630	Continued From page 17 *UAP C stated the night shift employees were to monitor and document the temperatures. *She was not certain why that was not being done consistently. 2. Review of the Luke John medication room refrigerator and temperature logs and continued with UAP C on 3/25/25 at 4:14 p.m. regarding the temperature of the Luke John medication refrigerator and room revealed: *The log was formatted differently than the log for the Mathew Mark medication room refrigerator and room temperature log. *The Luke John log included an area to document the refrigerator location, month, year, date, temperature and employee signature. -There was no area to document the room temperature. -The documentation included the location of "Luke John Med [medication room]", the month of "March", and the year of "2025". -The areas for documenting the refrigerator date, temperature, and signature were completed from the first through the twenty-fourth. *UAP C was not aware the temperature of the Luke John medication room was not being monitored. 3. Interview on 3/26/25 at 8:42 a.m. with registered nurse B regarding monitoring and documenting temperatures of the medication refrigerators and rooms revealed: *The night shift employee was responsible to monitor and document those temperatures. -Several of the night shift employees were recently hired. *She not aware that the room temperature of the Luke John medication room was not being monitored and documented. *She was not certain why there were two different	S 630		

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S 630	Continued From page 18 log forms used for the documentation of those temperatures. 4. Interview on 3/26/25 at 10:10 a.m. with Senior Living Manager A regarding medication refrigerator and room temperature monitoring and documentation revealed he was not aware this was not always being completed. He did not offer additional information or feedback. 5. Review of the provider's 9/23/24 Medication Acquisition, Receiving, Packaging, and Storage policy revealed: *"Refrigerators holding medications (such as insulin, etc.) will have temperatures maintained between 36 [degrees] F [Fahrenheit] and 46 [degrees] F. Medication room temperatures will be maintained between 59 [degrees] F and 86 [degrees] F. Refrigerator temperatures will be checked daily, adjusted as necessary and documented on the Refrigerator/Freezer Temperature Log". 6. Review of the provider's 3/19/25 State-Specific Senior Living Information policy revealed: *"Storage and labeling of medications" -"Medications suitable for storage at room temperature must be maintained between 59 and 86 degrees Fahrenheit. Medications requiring refrigeration must be maintained between 36 and 46 degrees Fahrenheit."	S 630		
S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication	S 632	Unable to correct prior deficient practices. Resident 5's medications have proper labeling on them. All residents are at potential risk if medications are not labeled properly. Education will be provided by the Nurse Manager to all nursing staff regarding proper labeling of all medications. Nurse Manager or designee will audit medications for proper labeling for compliance weekly x3, every other week x3 and monthly x3. Nurse Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Nurse Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25

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S 632	Continued From page 19 received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure medications were properly labeled for one of one sampled resident (5) for two of two observed medication bottles. Findings include: 1. Observation and interview on 3/25/25 at 3:05 p.m. with unlicensed assistive personnel C of a medication cart revealed: *The medication cart contained resident 5's medications. -Two bottles of medications did not have a pharmacy label on them. -Resident 5's name was written in permanent marker on each of them. --One bottle had the manufacturer's label of "L-Lysine 1000 mg [milligram]". --The second bottle had the manufacturer's label of "Omega Pure EPA-DHA 720" (EPA and DHA stands types of long-chain omega-3 fatty acids found in fish, shellfish, and some algae.) *UAP C confirmed: -The bottles contained over-the-counter medications that had been prescribed for resident 5 by her physician.	S 632		

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S 632	Continued From page 20 -There were no pharmacy labels on the bottles that provided the instructions for administration related to the physicians' order. Interview on 3/26/25 at 8:44 a.m. with registered nurse B regarding labeling of residents' medications revealed: *All medications should have a pharmacy label that includes the required identifying information and instructions for use. *The medication label should match the physician's order for that medication. Interview on 3/26/25 at 10:10 a.m. with Senior Living Director A regarding labeling of residents' medications revealed he acknowledged the non-compliance but did not offer additional information or feedback. Review of the provider's 9/17/24 Medication Administration policy revealed: *"Purpose: To provide general procedures for safe administration and documentation of medication;" -"Each medication administered by the ALC will be properly labeled for the individual resident." -"A provider's order for any medication is required and must include the diagnosis, the medication name, dose, route and frequency."	S 632	Unable to correct prior deficient practices. Resident 4, 6, 7, 8, and 9's medications have been destroyed. All residents are at potential risk if medications are not destroyed per policy. Education will be provided by the Nurse Manager or designee to all nursing staff regarding medication destruction. Nurse Manager or designee will audit destruction logs for proper documentation for compliance weekly x3, every other week x3 and monthly x3. Nurse Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Nurse Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25
S 650	44:70:07:06 Drug Disposal Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy.	S 650		

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	66221	A. BUILDING: _____ B. WING _____	03/26/2025

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S 650	Continued From page 21 This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to ensure five of five randomly observed residents (4, 6, 7, 8, and 9) medications had been disposed of by two authorized personnel. Findings include: 1. Observation and interview on 3/25/25 at 3:09 p.m. with unlicensed assistive personnel (UAP) C regarding medication destruction revealed: *There was a locked file cabinet in the main office. In that locked cabinet there were individual file folders for each resident that contained a "Medication Destruction Log" form and medications that were to be destroyed for that resident. -Those forms included areas to document the resident name, admission, date, and physician. -This form included columns to document the date disposition, the prescription number, the medication name/strength, the amount destroyed, the method of destruction, and signatures of the nurses or pharmacist witnessing the disposition. *UAP C indicated the medications were be listed on the form only when the medications were destroyed. -She confirmed the form in each resident's file that contained medications to be destroyed, did not have those medications listed on the forms. -She confirmed there was no way to identify if any of the medications were missing. 2. Review of resident 4's medication destruction log revealed three prescribed medications were destroyed in an RX destroyer (a container of liquid solution that deactivates and destroys	S 650		

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	66221	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 650	Continued From page 22 medications) with no signatures of who destroyed the medications including: *On 1/31/24 two potassium tablets (for low potassium levels) and two Furosemide tablets (a diuretic used to decrease fluid buildup in the body). *On 4/10/24 sixty-one midodrine tablets (for low blood pressure). 3. Review of resident 6's medication destruction log revealed ten prescribed medications were listed as destroyed in an RX destroyer with no signatures of who destroyed those medications including: *On 4/10/24 one tamsulosin (for urine flow) tablet, one Gabapentin (for seizures or pain) tablet, and one cephalexin (an antibiotic) tablet. *On 6/22/24 ninety-four docusate sodium (stool softener) tablets, twenty-four ICaps multivitamin tablets, four Gabapentin tablets, one fish oil supplement tablet, one metoprolol (for high blood pressure) tablet, three Ocuvite eye supplement tablets, and one vitamin D3 tablet. 4. Review of resident 7's medication destruction log revealed one prescribed medication was listed as destroyed in an RX destroyer with no signatures of who destroyed that medication including on 6/10/24 that included one-half of a Diclofenac gel (for relieving pain from arthritis joints) tube. 5. Review of resident 8's medication destruction log revealed two prescribed medications were listed as destroyed in an RX destroyer with no signatures of who destroyed that medication including on 7/9/24 that included 180 acetaminophen tablets and 90 famotidine (for stomach acid) tablets.	S 650		

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	66221	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 650	Continued From page 23 6. Review of resident 9's medication destruction log revealed seven prescribed medications were listed as destroyed in an RX destroyer with no signatures of who destroyed those medications including on 2/9 (no year was listed) that included one potassium tablet, one Omega 3 Fish Oil tablet, one vitamin B12 tablet, one Culturelle tablet, one aspirin tablet, one calcium tablet, one Cephalexin tablet, and one vitamin D3 tablet. 7. Interview on 3/26/25 at 8:31 a.m. with registered nurse B regarding medication destruction revealed: *The medications that were to be destroyed were kept in a locked storage cabinet. -These medications were to be documented on the Medication Destruction form when placed in the cabinet. -Those medications would then be destroyed at a later time, documented as destroyed, and the individuals who destroyed the medications would then sign the form. *She confirmed the Medication Destruction forms had not been completed accurately. *She stated, she and UAP C had destroyed resident 9's medications together and had not signed the destruction form. 8. Interview on 3/26/25 at 10:12 a.m. with Senior Living Manager A regarding residents' medication destruction revealed he acknowledged the non-compliance but did not offer additional information or feedback. 9. Review of the provider's 3/19/25 State-Specific Senior Living Information policy revealed: *"The facility will maintain records that account for all medications and drugs from receipt through administration, destruction, or return." *"Drug disposal. Legend drugs not controlled	S 650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 650	Continued From page 24 under SDCL [South Dakota Codified Law] chapter 34-20 B shall be destroyed or disposed of by a nurse and another witness." 10. Review of the provider's 11/8/24 Disposition of Medication policy revealed: *"Destruction - In the case of controlled, non-controlled, dropped, outdated and/or discontinued medications that need to be destroyed, the following procedure will be used: -1. Non-controlled medications will be destroyed by a licensed nurse and another witness, or according to state regulations. Signatures will be required of those individuals involved in the destruction."	S 650		