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
	41022	A. BUILDING: _____ B. WING _____	C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEL-LIFE AT ELK POINT	600 EAST LINCOLN STREET ELK POINT, SD 57025

(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 6/15/26 through 6/16/26. Wel-Life At Elk Point was found not in compliance with the following regulations: S105, S165, S296, S305, S315, S331, S337, and S685. 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 6/15/26 through 6/16/26. Areas surveyed included quality of life and resident rights. Wel-Life At Elk Point was found in compliance.	S 000		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interviews, and policy review, the provider failed to prevent the potential for cross-contamination from raw hamburger to ready to eat foods such as sliced tomatoes in the kitchen. Findings include:	S 105	1. During survey review it was determined that a cook placed raw hamburger on the counter next to vegetables potentially causing cross contaminiation. Upon discovery, the hamburger was placed away from the vegetables. No residents were harmed. 2. Dietary director to review food handling policy with all kitchen staff by July 15, 2026. 3. Dietary director to complete written audits by completing random observations of food handling practices by cooks. The audits will occur weekly for 4 weeks, monthly for 3 months, and continue as needed based on results. 4. Results from written audits will be reviwed by Executive Director to ensure compliance.	7/20/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Wittrock RN
TITLE: Executive Director
(X6) DATE: 7/14/2026

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S 105	Continued From page 1 1. Observation on 6/16/26 at 11:23 a.m. in the kitchen revealed there was a plastic bag of raw hamburger stored on the counter. The area where the hamburger was stored was also used for vegetable preparation. Around the bag of raw hamburger was a cutting board with a knife, a bowl of sliced tomatoes and some lettuce scraps. 2. Interview on 6/16/26 at 11:25 a.m. with cook E revealed she had placed the raw hamburger on the counter because she was going to cook it next. She did not consider the potential for cross-contamination from storing and handling raw foods in areas where ready-to-eat foods were prepared and stored. 3. Interview with vice president of operations C on 6/16/26 at12:01 p.m. confirmed raw hamburger should not have been stored on the counter in an area where ready to eat foods were prepared or stored. 4. Review of the undated Food Safety requirements policy revealed "It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food safety. Food service safety refers to handling, preparing, and storing food in ways that prevent foodborne illness. Food safety practices shall be followed throughout the facility's entire food handling process."	S 105	Type text here	
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged,	S 165	1. During survey review it was determined that oxygen tanks were not stored properly in rack. Instead, they were free-standing on the floor of the oxygen storage room. No residents were harmed. 2. In the staff meeting on 6/30/2026 the oxygen tanks policy was reviewed by Executive Director.	7/20/26

Jennifer Wittrock Executive Director 7/14/2026

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S 165	Continued From page 2 equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to store five empty oxygen cylinders in racks or holders in the oxygen storage room. Findings include: 1. Observation and interview on 6/16/26 at 10:00 a.m. in the oxygen storage room with director of maintenance D revealed there were four 682-liter tanks and one 170-liter tank free standing in the oxygen storage room. Director of maintenance D confirmed that those tanks should have been stored in a rack or holder. 2. Review of the March 2019 Oxygen Tanks Policy revealed "oxygen cylinders must be stored in racks with chains, sturdy portable carts and /or approved stands." "Oxygen cylinders may not be left free standing."	S 165	3. Director of Health Services to complete written audits on spot checks of oxygen storage room to ensure tanks are stored properly. Audits to be done weekly x 4 weeks, monthly x 3 months and continued as needed based on results. 4. Executive Director to review written audits to ensure compliance.	
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response;	S 296	1. During survey review it was discovered that required personnel training was not documented as completed within 30 days of hire. 2. Personnel training program, based on South Dakota regulations, reviewed by VPO and Executive Director.Additional training programs entered into employee onboarding. If not available online, topics to be presented to staff by Executive Director upon hire and annually. 3. Executive Director to provide time during new .	7/20/26

Jennifer Wittrock Executive Director July 14 2026

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S 296	Continued From page 3 (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure the required training was completed within 30 days of their hire date for five of six newly hired sampled employees (A, F, G, I, and J). Findings include:	S 296	Hire orientation for hires to complete required training before proceeding with other orientation topics. Audits will be complete on new hires weekly x 4 weeks, monthly x 3 months and continued on an ongoing basis,as needed ,by Executive Director. 4. VPO to review audits to ensure compliance.	

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S 296	Continued From page 4 1. Review of employee A's personnel file revealed she was hired on 3/24/25 and was the executive director. There was no documentation that she received training on fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, resident rights, confidentiality, incidents and diseases subject to mandatory reporting and the facility's reporting mechanism, nutritional risks and hydration, abuse, neglect, and misappropriation of resident property and funds, problem solving, hospice, and oxygen within 30 days of her hire date. 2. Review of employee F's personnel file revealed she was hired on 11/20/25 and was the director of dietary. There was no documentation that she received training on fire prevention and response and infection control and prevention within 30 days of her hire date. She had received training on accident prevention and safety procedure on 2/1/26 which was not within 30 days of her hire date. 3. Review of employee G's personnel file revealed she was hired on 12/2/25 and was a dietary aide. She had completed the required training on 4/7/26 which was not within 30 days of her hire date. 4. Review of employee I's personnel file revealed she was hired on 1/12/26 and was a certified medication aide (CMA). There was no documentation that she received training on fire prevention and response, emergency procedures and preparedness, accident prevention and safety procedures, resident rights, confidentiality, nutritional risks and hydration, abuse, neglect, and misappropriation of resident property and	S 296		

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S 296	Continued From page 5 funds, problem solving, hospice, and oxygen within 30 days of her hire date. She had completed infection control and prevention and incidents and diseases subject to mandatory reporting and the facility's reporting mechanism on 3/15/26 which was not within 30 days of her hire date. 5. Review of employee J's personnel file revealed she was hired on 1/7/26 and was a CMA. She had complete fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, resident rights, confidentiality, incidents and diseases subject to mandatory reporting and the facility's reporting mechanism, nutritional risks and hydration, abuse, neglect, and misappropriation of resident property and funds, problem solving, hospice, and oxygen between 4/7/26 and 4/12/26 which was not within 30 days of her hire date. 6. Interview on 6/16/26 at 11:30 a.m. with executive director A and vice president of operations C regarding new employee training revealed employees A, F, G, I, and J did not receive the above training's within 30 days of their hire dates and should have. It was executive director A's responsibility to oversee that the staff training was completed within 30 days of their hire date. 7. Interview on 6/16/26 at 12:40 p.m. with vice president of operations C confirmed they did not have a Personnel Training policy.	S 296	Type text here	
S 305	44:70:04:05 Personnel Health Program	S 305	1. During survery review it was discovered that employees F,G, H were not evaluated by a licensed health professtional within 14 days of hire.	7/20/26

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S 305	Continued From page 6 The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to ensure three of six sampled employees (F, G, and H) were evaluated by a licensed health professional and determined to be free from communicable diseases within fourteen days of being hired. Findings include: 1. Review of the personnel file for employee F revealed she was hired on 11/20/25 and was director of dietary. The evaluation by a licensed health professional was completed on 6/15/26. That was seven months after she was hired. 2. Review of the personnel file for employee G revealed he was hired on 12/2/25 and was a dietary aide. There was no documentation that employee G was evaluated by a licensed health professional after she was hired. 3. Review of the personnel file for employee H revealed she was hired on 7/14/25 and was the activity director. There was no documentation that she was evaluated by a licensed health professional after she was hired. 4. Interview on 6/16/26 at 11:30 a.m. with executive director A and vice president of	S 305	2. On the day of survey, employee H sent completed health questionnaire to Executive Director, who then placed in employees file. On 6/9/26 employee G brought her completed health questionnaire to building and it was placed in employee file. On 6/22/26 Executive Director and Director of Health Services reveiwed all employee files and ensured health questionnaire was present. Director of Health Services and Executive Director reviewed employee health requirements based on South Dakota regulations. 3. Upon hire, Executive Director to audit all personnel within 14 days of hire and provide written audits weekly x 4 weeks and monthly x 3 months, and ongoing, based on audit results. 4. VPO to review written audits to ensure compliance.	

Jennifer Wittrock Executive Director 7/14/26

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S 305	Continued From page 7 operations C revealed employees F, G, and H were not evaluated by a licensed health professional within fourteen days of their employment and should have been. 6. Review of the provider's South Dakota 12/5/12 Associate Health Questionnaire policy revealed "An Associate Health Questionnaire is completed in-house and is completed and signed by a licensed health profession."	S 305	Type text here	
S 315	44:70:04:07 Prevention And Control Of Influenza Each facility shall arrange for an influenza vaccination to be completed annually for each resident. Each resident shall be offered influenza vaccine when the resident is admitted and annually during the influenza season. 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, interview, and policy review, the provider failed to ensure documentation was completed for one of four sampled resident (1) that they were offered the influenza vaccination, or if they refused it annually. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 6/28/25. There was no documentation that she was offered or refused the influenza vaccination annually.	S 315	1. Survey review determined that resident I did not have documentation of receiving or declining Influenz vaccine annually. No resident were harmed. 2. On 7/8/26 Executive Director and Director of Health Services reviewed Influenza requirements based on SD regulations. All resident charts were audited for Influenza status or declination. Residents who have neither will be offered by 7/20/26 and charts will be udpated. 3. The exisiting process, based on regulations, will provdie guidance to the Director Of Health Services ongoing. Director of Health Services will perform written audits of resident charts weekly x 4 weeks, monthly x 3 months, and ongoing as needed to ensure new admissions and current residents are offered Influenza vaccines or are assisted with declinations annually. 4. Executive Director will review written results of audits to ensure compliance.	7/20/26

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S 315	Continued From page 8 2. Interview on 6/16/26 at 11:30 a.m. with executive director A regarding resident 1 revealed she should have been offered the influenza vaccination annually. 3. Review of the provider's November 2021 Influenza Vaccination - Resident policy revealed "1. All residents will be offered and encouraged to receive the influenza vaccine annually, unless there is a documented contraindication, or they have already received the vaccine for that individual season."	S 315	Type text here	
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 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	S 331	1. During survey review it was determined that employees A, F, G, H, I did not receive a 2 step TB skin test within 21 days of employment. Additionally, resident 8 did not receive a 2 step TB test within 21 days of admission. 2. ED reviewed TB policy with Director of Health Servicer on 6/18/2026. 3. Director of Health services will complete an audit of all current employees and residents by July 15, 2025 and begin 2 step TB skin test if needed.Tests will be performed on all new hires and admissions within 21 days. 4. Executive Director to audit employee files and resident charts August 1, 2026 to ensure compliance and to spot checks accordingly.	7/14/26

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S 331	Continued From page 9 completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure six of six sampled employees (A, F, G, H, I, and J) and one of four sampled resident (8) received a tuberculin (TB) two-step skin test or blood assay test within twenty-one days of employment, or admission, or provided evidence that the employees or the resident received a negative TB test in the months before employment or admission. Findings include: 1. Review of the personnel record for employee A revealed she was hired on 3/24/25 as the executive director. There was no documentation that she was tested for TB within twenty-one days of her employment. 2. Review of the personnel record for employee F revealed she was hired on 11/20/25 as director of dietary. A first-step TB skin test was completed 11/25/25. A second-step TB test was not documented as being given. 3. Review of the personnel record for employee G	S 331	Type text here	

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S 331	Continued From page 10 revealed she was hired on 12/2/25 as a dietary aide. There was no documentation that she was tested for TB within twenty-one days of her employment. 4. Review of the personnel record for employee H revealed she was hired on 7/14/25 as the activity director. A first-step TB skin test was completed on 1/16/25. A second-step TB test was documented as being given. 5. Review of the personnel record for employee I revealed she was hired on 1/12/26 as a certified medication aide (CMA). There was no documentation that she was tested for TB within twenty-one days of her employment. 6. Review of the personnel record for employee J revealed she was hired on 1/7/26 as a CMA. There was no documentation in her personnel record to support she had been tested for TB within twenty-one days of employment. 7. Review of resident 8's closed care record revealed he admitted to the facility on 4/22/25. There was no documentation that he was tested for TB within twenty-one days his of admission. 8. Interview on 6/16/26 at 11:30 a.m. with executive director A regarding the above employees and resident's TB testing revealed they were not completed within twenty-one days of their hire date or admission, and should have been. 9. Review of the provider's November 2022 Tuberculosis Prevention & Control Program-South Dakota policy revealed "5. Resident Screening Tuberculosis [TB] Program. TB Screening at Admission. a. A resident's	S 331		

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S 331	Continued From page 11 clinical record must contain a report of the two-step method of a Tuberculin Skin Test (TST) to establish a baseline within 14 days of admission to a facility. Any two documented TST's completed within a 12 month period prior to the date of admission shall be considered a two-step. Symptoms screen must also be completed." "Tuberculosis control Plan for Health Care Workers. b. Each new healthcare worker shall receive the two-step TST to establish a baseline within 14 days of employment. Any two documented TSTs completed within a 12 month period prior to date of employment shall be considered a two-step. Healthcare workers/volunteers who have not had a TST test in the last 12 months shall have a two-step TST.	S 331	Type text here	
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 observation, care record review, interview, and policy review, the facility failed to ensure one of one sampled resident (5)received medications according to his physician's order by one of one certified medication aide (CMA) (K). Findings include: 1. Observation on 6/16/26 at 7:25 a.m. with CMA	S 337	1. During survey observation it was discovered that resident 5 did not receive medications at the time specified by orders. Resident was not harmed. 2. The Director of Health Services provided education to medication aides at staff meeting on 6/30/2026 regarding Medication Administration Rights. 3. The Director of Health Servies will audit medication administration vs orders and provide written results. This be audited weekly x 4 weeks, monthly x 4 months, and continued as needed based on results. 4. The Executive Director will review audits to ensure compliance.	7/20/26

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(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 337	Continued From page 12 K during medication administration with resident 5 revealed she plced his medications in a medication cup. Two of those medications were omeprazole 40 milligrams (mg) and Tamsulosin HCL 0.4 mg capsule. The instructions on the omeprazole bottle stated to give one hour before breakfast. The instructions on the Tamsulosin bottle stated to give after consuming a meal. CMA K handed resident 5 the medication cup. Resident 5 swallowed the medications. 2. Observation and interview on 6/16/26 at 8:00 a.m. resident 5 was observed to be eating breakfast in the dining room. Interview at that time with director of dietary F confirmed resident 5 was eating in the dining room. 3. Observation and interview on 6/16/26 at 9:00 a.m. with director of health services B regarding resident 5's medications revealed that she confirmed the omeprazole 40 mg bottle instructions indicated to take the medication one hour before breakfast and the Tamsulosin HCL bottle instructions indicated to take the medication after consuming a meal. She expectated the medications to be given according to the physician's order. 4. Review of the provider's November 2022 Administration of Medication policy and procedure revealed "A physician order is required for all medications the staff administers. A person who satisfies the training requirements may administer medications." 5. Review of the provider's March 2019 Physician Order policy revealed "To correctly and safely receive and transcribe physician's orders. The procedure revealed "5. all orders must contain name, strength, route, dose, and quantity or	S 337		

Jennifer Wittrock Executive Director July 14 2026

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	41022	A. BUILDING: _____ B. WING _____	C 06/16/2026

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S 337	Continued From page 13 specific duration of therapy. 6. Order must also contain specific and clear parameters. a). Dose. b). Time (Needs to state the amount of time between dosage.)"	S 337	Type text here	
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. 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 three of four sampled residents (2, 4, and 8) who self-administered their medications were evaluated quarterly to ensure they were able to administer their medications safely. Findings include:	S 685	1. During survey review it was determined that resident 2 did not have a self administration of medication assessment documented or a physician order to do so. Resident self administers insulin. Resident was not harmed. 2. Current self administration of medications policy reviewed by Executive Director and Director of Health services on 6/18/26. Residents 2 and 4 did not have current self administration of medications assessments charted, these were completed. Executive Director and Director of health servies to jointly work on new admissions current residents to ensure asessments are being completed timely. 3. Director of Health services to complete written audits weekly x 4 weeks and monthly x 3 months of residents needing self administration of medication assessments. 4. Executive Director to review written audits to ensure compliance.	7/20/26

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S 685	Continued From page 14 1. Review of resident 2's care record revealed he admitted to the facility on 6/23/25. His diagnoses included type II diabetes mellitus and vascular dementia with agitation. His 6/25/25 mini mental state examination (MMSE) (cognitive screening) assessment score was 12 out of 30, which indicated his cognition was moderately to severely impaired. His 4/8/26 MMSE assessment score was 11 out of 30, which indicated his cognition was severely impaired. His 5/8/26 service plan revealed "unable to self-administer insulin" because he had a diagnosis of dementia. Medications were to be administered by licensed or certified team members. He received Novolin N insulin twice a day. There was no documentation a self-administration of medications assessment was completed or a physician's order was obtained to determine he could self-administer his insulin. 2. Review of resident 4's care record revealed she admitted to the facility on 6/2/23. Her diagnoses included anxiety disorder (persistent, excessive, and uncontrollable fear or worry), obesity, and disease of the spinal column. Her 5/2/25 MMSE assessment score of 30 out of 30 which indicated her cognition was intact. There was a physician's order that indicated she could self-administer her medications. Her 5/18/26 service plan addressed she was independent with self-administration of medications. 3. Review of resident 8's closed care record revealed he admitted to the facility on 4/22/25 and discharged to his home on 1/25/26. He had diagnoses of type II diabetes mellitus, hypertension, and malignant neoplasm (cancer) of the prostate. His 11/12/25 MMSE assessmemt score was 23 out of 30, which indicated his cognition was mildly impaired. His 1/14/26 service	S 685		

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S 685	Continued From page 15 plan indicated the "insulin pen was to be dialed up by [the]staff, but [the] resident is able to do own injection with staff observation." The physician's order indicated that he received Novolog insulin "three times a day" and Tresiba insulin at "bedtime everyday." "There was no physician's order for him to self-administer his medications or a self-administer assessment completed. 4. Interview on 6/15/26 at 1:00 p.m. with director of health services B regarding resident 8 self-administering his insulin revealed he could administer the insulin after the staff dialed up the dose. 5. Interview on 6/15/26 at 3:00 p.m. with director of health services B revealed the above residents who self-administered medications revealed she had completed self-administration assessments for residents who took their own medications. She did not complete the assessments on residents who self-administered insulin. The certified medication aide (CMA) would dial up the insulin, hand the insulin pen to the resident, and the resident would self-administer it. She agreed residents 2, 4, and 8 should have had a self-administration assessment completed for insulin administration. 6. Review of the provider's November 2022 Self-Administration of Meds (medications) policy revealed "1. Each resident has a right to self-administer medications unless this practice is determined unsafe. 2. Upon admission or during their stay, nursing will ask each resident if they would like to self-administer medications. 3. If the resident has expressed a desire to self-administer, the RN (registered nurse) will complete and assess the resident's cognitive, physical, and visual ability to carry out this	S 685		

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S 685	Continued From page 16 responsibility. 4. Re-assessment will be completed annually or as needed." "6. Nursing is to get an order from the physician for self-administration of medications. 7. The Service plan shall reflect the resident's self-administration status."	S 685		

Jennifer Wittrock Executive Director July 14 2026