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
	55871	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND SENIOR LIVING-RUSHMORE, LLC	417 E FAIRLANE DRIVE 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 on 1/22/25. The area surveyed was resident neglect. Heartland Senior Living-Rushmore, LLC was found not in compliance with the following requirements: S167 and S835.	S 000		
S 167	44:70:02:17(3) Occupant Protection The facility shall: (3) Provide an emergency staff call system for resident use to summon assistance from staff. The system must be capable of being easily activated by a resident and must register both visually and audibly at the staff station. The system must be utilized and maintained in a manner to ensure it is a consistent and effective means for a resident to alert staff of the need for assistance. The call system must also: (a) Utilize fixed call stations convenient for resident use and activated by a pull cord or other department-approved device. The fixed call stations must be located at each bed, toilet, and bathing facility used by a resident; (b) Be a wireless system with a device carried by a resident; or (c) Have been submitted for review and approved by the department; A call station or device is not required in the resident room of a cognitively impaired resident if a nursing assessment determines the resident would not benefit from the availability;	S 167	Facility moved resident and she has been re-located. Building has been closed for all further assisted living services. Dept Of Health has been notified and officially closed the License Number associated with this address and facility. No further services will exist at this address.	2/1/2025

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

Jesika Floyd | Administrator | 2/4/2025

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S 167	Continued From page 1 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 provide an emergency staff call system for one of one sampled resident's (1) use to summon assistance from staff. Findings include: 1. Interview on 1/22/25 at 9:05 a.m. with registered nurse (RN) B revealed: *Resident 1 was moved from building 10771 to building 55871 after building 10771 was closed the beginning of January 2025. -She was expected to remain in building 55871 until there was an open room for her to move into in one of the other buildings on the campus. *Resident 1 was the only resident who resided in building 55871 and there were no staff scheduled to work in that building. -The resident walked to building 11034 to eat her meals and caregivers checked on her in building 55871 "hourly." Observation and interview on 1/22/25 at 9:15 a.m. with resident 1 in building 55871 revealed: *She was "waiting for [staff to administer] her pills." *She had lived alone in the building for about "1-2 weeks." -She expected other residents would have moved into the building with her. *She had no call light pendant in her room and no call light in her bathroom that she could have used to alert staff if she had needed assistance. -Staff had checked on her about "every two to three hours." *She used a cane when she walked. Review of resident 1's electronic medical record (EMR) revealed:	S 167		

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S 167	Continued From page 2 *Her admission date was 4/9/24 and she was 75 years old. *Her medical diagnoses included: neurocognitive disorder with Lewy bodies [abnormal protein clumps that build up in the brain, causing a progressive form of dementia], hypertension, insomnia, Alzheimer's disease with late onset, and acid reflux. Interview on 1/22/25 at 2:45 p.m. with administrator A revealed: *Resident 1 was moved on or around 1/11/25 from building 10771 to building 55871. -Building 55871 had been unoccupied for "four to five years" before resident 1 was moved there. -Resident 1 was the sole occupant of that building and there were no staff scheduled to work in that building. *There was no functioning resident call light system in building 55871 for resident 1 to have used if she had needed staff assistance. -Staff checked on the resident at least every two hours and the activity director's office was in building 55871. *The facility failed to maintain resident 1's safety by ensuring she had access to an emergency call system. Review of the provider's undated Assisted Living Center Services and Pricing revealed: *Basic Room Pricing Includes: -24-hour emergency call system Refer to S835.	S 167		
S 835	44:70:09:09(1) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life,	S 835		

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S 835	Continued From page 3 including: (1) A safe, clean, comfortable, and homelike environment; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, observation, record review, and the provider's services and pricing list review, the provider failed to ensure adequate staffing supervision and a safe environment that contributed to the quality of life for one of one sampled resident (1). Findings include: 1. Interview on 1/22/25 at 9:05 a.m. with registered nurse (RN) B revealed: *Resident 1 was moved from building 10771 to building 55871 after building 10771 was closed the beginning of January 2025. -She was expected to remain in building 55871 until there was an open room for her to move into in one of the other buildings on the campus. *Resident 1 was the only resident who resided in building 55871 and there were no staff scheduled to work in that building. -The resident walked to building 11034 to eat her meals and caregivers checked on her in building 55871 "hourly." Observation and interview on 1/22/25 at 9:15 a.m. with resident 1 in building 55871 revealed: *No other residents lived in that building. -The rooms and hallways of the building were used for storage. *Resident 1's room was next door to a kitchen and was furnished with her personal belongings. *She was "waiting for [staff to administer] her pills."	S 835		

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S 835	Continued From page 4	S 835		

*She had lived alone in the building for about "1-2 weeks."
-She expected other residents would have moved into the building with her.
*She had no call light pendant in her room and no call light in her bathroom that she could have used to alert staff if she had needed assistance.
-Staff had checked on her about "every two to three hours."
*The west (main entrance of the building), south, and north doors were unlocked. The east door was locked.
-Alarms on the south and north doors had been disengaged and no longer worked.
*The resident used a cane for mobility.

Review of resident 1's electronic medical record (EMR) revealed:
*Her admission date was 4/9/24 and she was 75 years old.
*Her medical diagnoses included: neurocognitive disorder with Lewy bodies [abnormal protein clumps that build up in the brain, causing a progressive form of dementia], hypertension, insomnia, Alzheimer's disease with late onset, and acid reflux.
*A 1/11/25 quarterly care note completed by RN B: "Very independent lady likes to walk several times a day and when nice goes outside. She was moved to a new room and is adjusting to the surroundings well. She voices no complaints or concerns. Gets along well with other resident she prefers to watch her TV game shows and work on her crafts then participate in group activities.
*The resident's 1/6/25 Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated she had no cognitive impairment.

Review of resident 1's care plan initiated on 4/12/24 revealed:

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S 835	Continued From page 5 *Focus: Safety *Goal: "To be safe while living in [the] community." *Intervention: "Safety Check" Every 2-3 hrs [hours]." Review of resident 1's 1/1/25 through 1/21/25 every two-hour visual check documentation revealed: *There was no documentation that indicated visual checks had been completed 1/11/25 through 1/15/25, 1/17/25 through 1/18/25, or on 1/21/25. -The average daily number of visual checks documented for the remaining thirteen days of that time period was 4.2 visual checks per day. Interview on 1/22/25 at 2:45 p.m. with administrator A revealed: *On or around 1/8/25 or 1/9/25 two of the three residents who lived in building 10771 had moved out. That had left resident 1 as the sole occupant of that building. -One staff person was scheduled to work in that building until those two residents moved out. *After the two residents moved, resident 1 remained in that building but there were no longer staff scheduled to work in that building. *There had been no rooms available in either building 10760 or 11034 for resident 1 to have moved into. *Resident 1 was moved on or around 1/11/25 to building 55871. -There were no staff scheduled to work in that building after resident 1 was moved there. *It was "the lesser of two evils" and safer for the resident to have moved to building 55871. Its physical proximity to the adjacent building was closer in proximity than the other buildings. -Staff checked on the resident at least every two	S 835		

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S 835	Continued From page 6 hours and the activity director's office was in building 55871. -The caregiver's smoking area was outside of building 55871 and they were expected to have checked on the resident after their smoke breaks. *There was no functioning resident call light system in building 55871 for resident 1 to have used if she had needed assistance. *Administrator A had not notified the South Dakota Department of Health that building 10771 was closed or that building 55871 had reopened, occupied by resident 1, and was unstaffed. -Building 55871 had been unoccupied for "four or five years" before resident 1 was moved there. *She confirmed resident 1 had met the criteria for assisted living level of care and not an independent living level of care. *The facility failed to provide resident 1 staff supervision in a safe environment. *Another local assisted living center was expected to assess resident 1 on 1/23/25 for potential admission to their facility. Review of the provider's undated Assisted Living Center Services and Pricing revealed: *Basic Room Pricing Includes: -24-hour emergency call system -24-hour staffing in all buildings	S 835		