STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67742	A. BUILDING: _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGENDS ON LAKE LORRAINE	2815 SOUTH WESTLAKE DR SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 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 11/27/23 through 11/29/23. Legends On Lake Lorraine was found not in compliance with the following requirements: S105, S165, S173, S201, S296, and S450. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/27/23 through 11/29/23. Areas surveyed included abuse and neglect, service plans, memory care units, medication administration, accidents, coordination of care, and the discharge process. Legends On Lake Lorraine was found in compliance.	S 000	S 105	
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, cleaning schedule review, interview, and policy review, the provider failed to maintain the cleanliness for one of one kitchen. Findings include:	S 105	All identified areas of the kitchen have been cleaned to meet standard. All culinary employees will complete assigned training specific to sanitation and cleanliness by 1/13/24 on Relias in addition to review of Cleaning and Sanitation of Dining and Food Service Areas policy. All employees will sign to document review. Deep clean scheduled by outside agency for week of 12/25/23 to obtain baseline standard of cleanliness. Daily weekly and weeklycleaning schedule/chart has been implemented. Culinary Director or Designee will audit cleaning and sanitation at least weekly for the first 4 weeks and decrease based on compliance. Audit findings will be reported to the Quality Council meeting. The next QA meeting is scheduled for 1/4/24, the plan of correction will be reviewed at this meeting.	1/13/24

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

Executive Director — 12-29-23

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S 105	Continued From page 1 1. Observation and cleaning schedule review on 11/27/23 from 3:05 p.m. through 3:30 p.m. in the kitchen revealed: *The kitchen floor had a layer of dirt and crumbs around the ice machine. *A portable food tray warmer had a mixer sitting on top of it. *The portable food tray warmer had streaks of frosting running down the side of it from the mixer. *The kitchen floor next to the oven and deep fat fryer had food crumbs scattered around each of them. *The top of the oven next to the grill was covered with grease, dust, and food crumbs. *The top of the upright refrigerator next to the deep fat fryer was covered in a thin layer of grease and food crumbs. *The daily/weekly cleaning schedule posted next to the walk-in refrigerator was dated 10/30/23 through 11/5/23 showed: -Documentation the daily tasks had been completed for that week. -The weekly cleaning tasks on the list had not been completed. -This was the only cleaning schedule they had. Observation and interview on 11/28/23 at 7:45 a.m. with waitstaff/server Q in the kitchen revealed: *The issues documented above from the observation the day before remained unchanged. *Waitstaff/server Q acknowledged the provider does have a cleaning schedule for the kitchen. *The dining services director monitors the cleaning schedule for tasks being completed. *Staff could get gift cards as incentives for completing tasks. *The more tasks staff complete the better chance	S 105		

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S 105	Continued From page 2 they had at getting a gift card. *She agreed the floor and other areas needed to be cleaned. Interview with dining services director E on 11/28/23 at 2:00 p.m. regarding the above observations and the daily/weekly cleaning schedule dated 10/30/23 through 11/5/23 revealed: *The staff were responsible to do the cleaning as scheduled. *She was responsible to ensure the staff were completing the cleaning tasks as assigned. *She had more recent cleaning schedules that documented staff cleaning but had thrown them away. *The new owners had provided new forms for them to use in the kitchen. *She agreed the kitchen needed a thorough cleaning. Review of the provider's revised 8/10/23 Cleaning and Sanitation of Dining and Food Service Areas policy revealed "The culinary services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with written, comprehensive cleaning schedules."	S 105		
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, 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.	S 165		

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S 165	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure processes were implemented for the safety of all residents using bed rails including for three of three sampled residents (2, 13, and 14). The provider had not ensured: *A safety evaluation was completed initially and then periodically for residents who had bed rails or positioning devices on their beds. *Manufacturers' instructions had been reviewed and followed for bed rails to ensure they were secured and used appropriately. *Safety guidelines regarding bed rail measurements had been followed. Findings include: 1. Observation on 11/27/23 at 4:45 p.m. of the Pearl Essence Memory Unit revealed: *Resident 14's bed had two attached bed rails. *On the left side of the bed the bed rail was thirty-nine inches long with a bar across the length dividing it into two four-inch-wide areas. The bed rail was partially covered by a cloth cover meant for bed rails. *The bed rail on the right side of the bed was measured at eleven inches wide by fourteen inches high and large enough to easily place an extremity through it. *Both bed rails were not secured against the mattress, as they were moveable leaving gaps between the rail and mattress. *This surveyor placed her arm between the rail and the mattress. *Interview at the above time with certified medication assistant (CMA) V regarding the bed rails revealed resident 14 used the bed rails to assist with repositioning.	S 165	Side rails for 3 identified residents (2,13, and 14) have been adressed. An audit of entire building has been conducted and all observed side rails were addressed. DON and nurses will proceed with bed rail safety evaluations, physician orders, risk/benefit agreement, and added to service plan for all identified residents with side rails. All residents who are apropriate based on above compliance will need to use one of 2 approved bed rails. Halo Safety Ring or Medacure Q Bar. Family members and residents will be educated on the dangers of side rails. All clinical staff members will complete side rail specific training by 1/13/24 in addition to review of bed rail policy with documented signature of review. DON or Designee will conduct chart audits to ensure safety evaluations, risk/benefit agreement, physician orders and service plans are all completed. Results of audits and plan of correction will be reviewed for compliance at monthly Quality Committee.	1/13/24

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S 165	Continued From page 4 Review of resident 14's care record revealed: *Her care/service plan had not identified the resident had bed rails. *Her assessment section of the care record had not contained bed rail assessments. *The use of bed rails or bed rail assessments had not been mentioned in her care record. 2. Observation on 11/29/23 at 9:30 a.m. of the Pearl Garden memory unit with registered nurse (RN) U revealed: *Resident 2's bed had one bed rail attached to the right side of the bed. *The bed rail was approximately thirty-nine inches long with a bar across the length dividing it into two four-inch-wide areas. The rail was partially covered. *The bed rail was not secured against the mattress, leaving gaps between the rail and mattress. *This surveyor could place her arm between the rail and the mattress. Review of resident 2's care record revealed: *His care/service plan: -Had not identified the resident had a bed rail. -Stated he was independent with turning and repositioning in bed. *His assessment section of the care record had not contained bed rail assessments. 3. Observation on 11/29/23 at 9:40 a.m. of the Pearl Garden memory unit with RN U revealed: *Resident 13's bed had one bed rail attached to the right side of the bed. *The bed rail was approximately thirty-nine inches long with a bar across the length dividing it into two four-inch wide areas. *The bed rail was not secured against the mattress, leaving gaps between the bed rail and	S 165		1/13/214

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S 165	Continued From page 5 mattress. *This surveyor could place my arm between the rail and the mattress. Review of resident 13's care record revealed: *His care/service plan: -Had identified the resident had a bed-cane (a type of bed rail) attached to his bed for assisting when repositioning in bed or getting our of bed. -Stated he was independent with turning and repositioning in bed. *His assessment section of the care record had not contained bed rail assessments. *Bed rail assessments had not been located in the care record. 4. Interview on 11/29/23 at 10:30 a.m. with regional health services director D regarding the above bed rails revealed: *She was not aware of the bed rails that were identified for residents 2, 13, and 14. *She had not known how many bed rails were being utilized in the building. *She had not known what the previous owner's bed rail policy was. *Her expectation was that each resident using bed rails would have been assessed for the need of bed rails and the safety of the bed rails being used. *She could not confirm if there were other bed rails in the building, because they had not checked the building for bed rails. *She confirmed the provider lacked a system process regarding bed rails being used in the facility which could have caused a safety concern for any resident who used them. *She stated the master assessment completed on admission did ask if the resident had used a bed rail but had not proceeded further with a bed rail evaluation but should have.	S 165		

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S 165	Continued From page 6 *She was aware of the Food and Drug Administration (FDA) guidelines for the use of bed rail safety. 5. Review of the new owner's 1/1/14 Bed Rail policy revealed: *When the community was aware that a resident was utilizing bed rails the community should assess the use, educate the resident and when appropriate, the responsible person regarding the risks and benefits of bed rails, and verify that the bed rail in use is of a safe design and utilized consistently with the manufacturer's directions. The policy should be followed regardless of who owned the bed rail. *The bed rail in use was to have been evaluated by the nurse and intended purpose of the bed rail and risks regarding the use of bed rails. *The staff from the assisted living community would determine if the bed rail was safe using all the requirements: -The rail was used consistent using the manufacturer's director. -Bed rails that slide between the mattress and box spring were prohibited, unless firmly attached to the frame. -Be aware of wobbly bed rails. -"The bed rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means bed rail zones 1, 2, and 3 [areas of high concern for entrapment] not to exceed 4.75" [inches]".	S 165		
S 173	44:70:02:17(8-9) Occupant Protection The facility shall: (8) Ensure that any clothes dryer must have a galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in	S 173		

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S 173	Continued From page 7 accordance with UL 2158A; and (9) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. A resident may store in the resident's room a maximum of three E-cylinders or seventy-two cubic feet, or 2.040 cubic meters of oxygen on an as-needed basis, in addition to oxygen in use by the resident. If a facility admits or retains a resident not capable of self-preservation, the facility must meet NFPA 101 Life Safety Code, 2012 edition, health care occupancy standards in chapter 18 or 19, or equip the facility with complete automatic sprinkler protection. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure: *Oxygen cylinders stored in one of one sampled resident's (1) room had been safely secured and stored. *No more than three full or empty E-cylinders had been stored in one of one sampled resident's (1) room, as required by the National Fire Protection Agency 99 Standard for Health Care Occupancies. *An oxygen storage room was available for storing full or empty oxygen cylinders. Findings include: 1. Observation on 11/27/23 at 3:30 p.m. in the Pearl Garden memory unit revealed: *Resident 1's door was open. *A cardboard oxygen E-cylinder storage container capable of storing eight E-cylinders safely was	S 173	Identified deficient duct work was determined to be UL 2158A compliant. Maintenance Director was able to locate label that indicates compliance. The identified non-compliant oxygen cylinders were removed from resident 1's apartment immediately and placed in safe area of med room. Resident Care Coordinator contacted oxygen vendor to coordinate delivery schedule that is consistent with orders and appropriate to be safely stored. Complete audit of resident that currently use oxygen completed to ensure safety storage requirements are met. Oxygen storage area of community has been identified and set up according to safety standards. All clinical staff members will complete assigned oxygen use and storage training on Relias and sign oxygen storage policy, completed by 1/13/24. Resident care coordinators will conduct weekly audits for 4 weeks and then monthly to ensure compliant oxygen storage practices. Results of audits will be reported to the DON and the QA committee. A committee will meet on 1/4/24 to review results of audits and discuss the plan of correction.	1/13/24

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S 173	Continued From page 8 observed. -The storage container had been placed just inside the door to resident 1's room next to his cupboard. -The E-cylinder storage container was full of cylinders. -Beside that container stood an unsecured E-cylinder of oxygen next to the pathway to enter the room. -On the other side of the pathway beside the room door stood an E-cylinder oxygen tank in a wheeled oxygen cart. *Under resident 1's desk were two cardboard B-cylinder storage containers, capable of storing four B-cylinder oxygen tanks in each container. -Beside the desk was another B-cylinder oxygen tank. It was unsecured. *Interview with resident 1 at the above time revealed he used the oxygen cylinders to go to the dining room. 2. Interview on 11/27/23 at 3:45 p.m. with caregiver/resident assistant L revealed she was not aware of who was responsible for taking care of the oxygen tanks and assisting the resident with the oxygen. 3. Interview on 11/28/23 at 9:20 a.m. with certified medication assistant (CMA) W regarding care of resident 1's oxygen cylinders revealed the CMA's assisted resident 1 with using and changing the cylinders when needed. 4. Interview on 11/28/23 at 10:30 a.m. with director of maintenance F regarding the care and storage of oxygen revealed all oxygen cylinders remained in the residents' rooms. There was nowhere else to store the cylinders. There was no oxygen storage room in the building. The maintenance department was not responsible for	S 173		

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S 173	Continued From page 9 oxygen storage or transporting the oxygen. 5. Observation and interview on 11/29/23 at 9:45 a.m. with the interim director of nursing U and region health services director D regarding resident 1's oxygen cylinders storage, safety, and abundance of cylinders revealed the provider: *Had not known who was responsible for maintaining the storage and safety of the cylinders. *Needed to contact the oxygen supplier to identify who would be responsible for maintaining the cylinders safety. *Had not known of the abundance of cylinders in resident 1's room and needed to move all but three cylinders out of the resident's room to ensure safe oxygen storage. 6. Review of the provider's reviewed 8/8/23 Oxygen policy revealed: *The facility would determine if the resident or facility was responsible for the ordering, refilling, and administration of oxygen. *If the facility accepted responsibility for the ordering, refilling, and administration of oxygen: -The oxygen would have been ordered in that same manner as medication. -The facility would coordinate with the resident's vendor of choice to schedule oxygen delivery at appropriate intervals. -Oxygen cylinders must remain upright at all times. Never tip an oxygen cylinder on its side or try to roll it to a new location.	S 173		
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	S 201		

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S 201	Continued From page 10 from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation, testing, and interview, the provider failed to maintain compliance with the 2012 Life Safety Code. Fire sprinkler heads were found obstructed in four rooms (kitchen dry storage, walk-in cooler, walk-in freezer, and catering storage), combustible storage was found in an exit corridor (service corridor behind kitchen), and a hazardous room door was found wedged open (housekeeping office and storage). Findings include: 1. Observation on 11/28/23 at 9:15 a.m. revealed four rooms within the culinary services area had blocked sprinkler heads. The heads were obstructed by stored items in the dry food storage area, the walk-in cooler, the walk-in freezer, and the catering storage room. Interview with the maintenance director F and the interim executive director A at the time of the observation revealed their understanding of the eighteen-inch clearance around sprinkler heads, and the necessity of reorganization within the rooms. 2. Observation on 11/28/23 at 9:30 a.m. revealed combustible storage in the exit corridor located adjacent to the kitchen. Two carts which had combustible boxes stacked on them were parked within the corridor. Interview with the maintenance director F at the time of the	S 201	The sprinkler heads in the 4 rooms identified have been cleared of obstruction. Indicators of the apropriate 18' placement from the ceiling have been placed in the kitchen dry storage, walk-in cooler, walk-in freezer and catering storage area to assist as a visual reminder to staff members of safety standards. All combustable carts have been removed from fire exit corridor. Sign has been placed in corridor to remind staff members to not store combustible items in this area. Door wedge was removed from housekeeping office and staff members edcuated on not proping doors. All staff members have been assigned fire safety training to be completed by 1/13/24. Maintenance Director and Cullinary Director will be conducting audits to monitor that sprinkler heads have 18' clearance, doors are not propped and exit areas are cleared of combustible items. Audits will be reviewed at QA meeting scheduled for 1/4/24 and ongoing until determined by committee. B. Fire drills will be conducted on all shifts rotating quarterly and will include resident participation per regulation. 3rd shift fire drill will be conducted on 12/28/23. All staff members will complete fire safety training by 1/13/24. QA committee will meet on 1/4/24 to to discuss plan of correction and review fire drill log to ensure compliance.	1/13/24

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S 201	Continued From page 11 observation revealed his understanding, but the interim executive director A, also interviewed at the time of the observation, was not aware combustible storage could not happen within an exit corridor. 3. Observation on 11/28/23 at 10:40 a.m. revealed a door wedge and a vacuum blocking open the door to the housekeeping office and storage area. The area was greater than 100 square feet, and contained hazardous storage including flammable liquids and would have been required to be closed or attached to an automatic hold open connected to the fire system. Interview with the maintenance director F and the executive director B at the time of the observation revealed understanding of the requirement. B. Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required third shift fire drills and no evacuation drills). Findings include: 1. Record review on 11/28/23 at 2:15 p.m. for three of four quarters reviewed since December 2022 revealed there was no documentation of third shift fire drills for quarter one in 2023 (January, February, March), quarter three in 2023 (July, August, September), or quarter four (October 2023, November 2023, December 2022) . First shift drills were completed in the months of June through September 2023, while second shift drills were completed during the months of January through March 2023 as well as May 2023. The only third shift drill was completed in April 2023. Fire drills are required to be performed once per shift in each quarter of a year to ensure the majority of staff participate in the training. Interview with maintenance director F	S 201		

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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 201	Continued From page 12 at the time of the record review confirmed those findings. He was unaware the minimum number of fire drills per shift per quarter had not been met for each shift for 2023. 2. Record review and interview on 11/28/23 at 2:15 p.m. with maintenance director F revealed fire drills were not used as an opportunity to train residents, as required by the Life Safety Code 32.7.2. Evacuation of residents was limited to those events which were unplanned. No night time evacuations were held as required by Life Safety Code 32.7.3. Maintenance director F revealed he was not aware of these requirements. The deficiency had the potential to affect 100% of the occupants of the building.	S 201		
S 296	44:70:04:04 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; (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;	S 296		

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	67742	A. BUILDING: _____ B. WING _____	C 11/29/2023

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LEGENDS ON LAKE LORRAINE	2815 SOUTH WESTLAKE DR SIOUX FALLS, SD 57106

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S 296	Continued From page 13 (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 employee file review, record review, interview, and policy review, the provider failed to ensure required training within 30 days of hire or assignment to the facility had occurred for the following: *One of ten newly hired sampled employee (L) and three of three sampled agency staff (R, S, and T) for all eleven required personnel training topics. *One of ten newly hired sampled employee (J) had only received two of the eleven required training topics. *Four of ten newly hired sampled employees (H, M, O, and P) had only received seven of the eleven required training topics. Findings include: 1. Review of employee L's personnel file revealed: *A hire date of 10/23/23. *She had been hired as a caregiver/resident assistant. *There was no documentation she had received	S 296	All employees will complete required training on topics 1-11 per regulation. Community has moved to Relias online training and determined to have all current staff members inlcuding new hires complete all required training through Relias by 1/13/24. All required trainings have been assigned to each employee. Department directors will monitor progress through Relias reports specific to employee progress and completion. Department directors will report employee compliance at QA meetings initially and ongoing monthly. All employees that have not completed required training will not be scheduled shifts after 1/13/24 until completed. Buisness Office Manager will present Relias training to all new hires on orientation and monitor progress specific to new employees. Agency staff member training has been implemented to include community specific policies and procedures. Training will be signed off on and monitored by scheduling coordinator. DON or Designee will conduct audits of training binders for agency staff members weekly ongoing and will report results to DON. Weekly audits and plan of correction will be reviewed by QA committee on 1/4/24 and monthly until compliance is determined by committee.	1/13/24 1/13/24

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S 296	Continued From page 14 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 and communication techniques related to residents with cognitive impairment or challenging behaviors. -Education based on the resident care needs (i.e. diabetes, oxygen use, hospice care). 2. Review of employee J's personnel file revealed: *A hire date of 10/9/23. *She had been hired as a certified medication assistant (CMA). *There was no documentation she had received training for: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -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. -Education based on the resident care needs (i.e. diabetes, oxygen use, hospice care). 3a. Review of employee H's personnel file revealed:	S 296		1/13/24

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S 296	Continued From page 15 *A hire date of 10/9/23. *She had been hired as a waitstaff/server. b. Review of employee M's personnel file revealed: *A hire date of 10/9/23. *She had been hired as a CMA. c. Review of employee O's personnel file revealed: *A hire date of 10/24/23. *She had been hired as a waitstaff/server. d. Review of employee P's personnel file revealed: *A hire date of 10/9/23. *She had been hired as a certified nursing assistant (CNA). e. There was no documentation employees H, M, O, and P had received training on: -Fire prevention and response. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism. -Nutritional risks and hydration. -Education based on the resident care needs (i.e. diabetes, oxygen use, hospice care). 4. Review of the provider's current list of assisted living residents revealed: *27 residents were identified as having a cognitive impairment and resided in one of the memory care units. *Eleven residents were identified as diabetic. *Four residents were identified as being on hospice care. *Three residents were identified as oxygen dependent. Interview on 11/29/23 at 12:35 a.m. with interim	S 296		

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S 296	Continued From page 16 executive director (ED) A revealed: *The current management company took over the operations for the provider on 9/20/23. *She was the business office manager (BOM), but presently was serving as the interim ED. *Since 9/20/23, the orientation process for new employees had included online computer training for the required training topics. *As BOM she was responsible for assuring new employees had completed their orientation within 30 days of being hired, but her role as interim ED had caused her to focus on those ED responsibilities. *She was not aware why the employees above had not completed their required training and she had not followed up with them regarding their training. *The online computer training was new to her and she was not sure what specific online training course fulfilled each of the individual required training topics. *She agreed with the findings above based on the individual employee's training transcript report and that employee L did not have a training transcript report. *The required training should have been completed for those employees. 5. Agency staff (R, S, and T) had no documentation they had received training on any of the eleven required training topics or that a facility-specific orientation had been completed. Review of the staffing schedule provided for the week of 11/25/23 through 12/1/23 revealed: *26 agency staff were assigned to work. -13 were assigned as resident aides. -11 were assigned as unlicensed medication aides. -One was assigned as director of nursing.	S 296		

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S 296	Continued From page 17 -One was assigned as a registered nurse. Interview on 11/28/23 at 3:40 p.m. with interim ED A, ED B, and director of nursing (DON) C revealed: *ED B had not been formally appointed as the executive director. *DON C had started at the facility yesterday, 11/27/23 and was currently in orientation and training for the DON position. *No personnel file was kept for agency staff and no documentation of orientation or training provided to agency staff was recorded. Interview on 11/29/23 at 12:35 p.m. with interim ED A regarding the agency staff revealed: *The provider only used one staffing agency. *The staffing agency was responsible to provide orientation and training for agency staff. *The provider had not provided facility information or policies to the staffing agency for that orientation and training. *The first shift an agency staff worked at the facility, the agency staff member was assigned to work alongside another staff member to be oriented to the facility, but no documentation was completed for that orientation. 6. Review of the 9/22/23 Health Care Staffing Agreement between the provider and the staffing agency revealed: *The staffing agency was responsible for: -Maintaining an employee file for each of its employees which contained: --Dates of employment and orientation. --Documentation of special education or training. --Orientation to the provider's policies and procedures for all new agency employees. *The provider was responsible for providing the staffing agency with provider and "facility	S 296		

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S 296	Continued From page 18 information and policies so that orientation of supplemental personnel may be given." *Both the staffing agency and the provider agree to: *"Comply with all federal, state and local laws and regulations." *"Consult and cooperate on a continuing basis with each other in the establishment of mutually acceptable standards and procedures for selection, training and assignment of personnel ..." On 11/28/23 at 5:00 p.m. a request was made for: *Agency employees R, S, and T's personnel file that included their orientation and training. *The facility information and policies that were provided to the staffing agency for employee orientation and training. *None of the requested documentation was provided by the end of the survey. Review of the provider's 10/1/2023 Orientation and Training policy revealed: *"All levels of employees are expected to complete required trainings within designated time frames." *"It is the responsibility of each employee, volunteer, or contract staff to complete required training." *"For training that is assigned as self-paced, the employee is responsible for completing the training by the deadline." *No specific time frames, required training, or deadlines were identified.	S 296		
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of	S 450		

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S 450	Continued From page 19 residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain a safe and sanitary food service environment related to food storage and the dating of packaged food in one of one kitchen. Findings include: 1. Observation and interview on 11/27/23 at 3:05 p.m. with cook N in the kitchen revealed: *A sign on the walk-in refrigerator door that stated please make sure EVERYTHING is labeled and dated that goes in the cooler. *Inside the walk-in refrigerator there was the following: -An undated Ziplock bag with corned beef slices. -An undated package with Canadian bacon slices covered with a plastic cling wrap. -Two undated five-pound bags of cheese. -An undated package of sun-dried tomatoes. -An undated Ziplock containing 12 biscuits. Interview with cook N at that time regarding the food dating process referred to above revealed he: *Knew the opened food items in the walk-in refrigerator should have had a date marked on them when they were opened. *Stated a lot of food goes in and out of the walk-in and sometimes things got overlooked. *Confirmed the food items were not dated when opened or when placed in the refrigerator. Interview with dining services director E on 11/28/23 at 2:00 p.m. regarding the food package	S 450	All food will be dated and stored according to regulation. All staff members will be trained on safe food storage specific to dating. All staff members will review and sign policy by 1/13/24. All staff members will complete required personnel training in Relias by 1/13/24. Cullinary director or Designee will audit all food storage areas to monitor compliance daily for the first 4 weeks. Results of the audit will be reported to the QA committee on 1/4/24 and ongoing monthly until compliance is determined by the committee.	12/28/23

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S 450	Continued From page 20 dating process revealed: *It was her expectation that food packages would have had an opened date on them to track quality and freshness. *The cooks were responsible for dating a package when it was opened. *She agreed food package dating was not completed on a consistent basis. Review of the provider's revised 8/10/23 Food Storage policy revealed: *"Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing." *"Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination." *"Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food should be consumed, sold, or discarded will be visible on all high-risk food."	S 450		

South Dakota Department of Health

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S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 4/10/24 through 4/11/24. Areas surveyed included neglect and nursing services. Legends On Lake Lorraine was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kyrsten Fokken

TITLE: Executive Director

(X6) DATE