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
	49893	A. BUILDING: ____ B. WING ____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

(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 7/9/25 through 7/10/25. Countryside Living was found not in compliance with the following requirements: S150, S165, S169, S201, S295, S296, S315, S320, S331, S337, S352, S775, and S820. 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 7/9/25 through 7/10/25. Area surveyed included nursing services. Countryside Living was found not in compliance with the following requirement: S337.	S 000		
S 150	44:70:02:13 Lighting Any space occupied by people, machinery, and equipment within buildings and their approaches and parking lots shall have artificial lighting at a level for general safety. Each resident bedroom shall have general lighting and night lighting. A reading light shall be provided for each resident who can benefit from one. Each required exit shall be equipped with continuous emergency lighting. Emergency power shall be provided if the main source of power fails. This Administrative Rule of South Dakota is not met as evidenced by: Based on testing and interview, the provider failed to maintain emergency lighting at the: *First floor C wing stairwell exit light. *First floor B wing exit light by the kitchen. *Second floor A wing exit light by the commons.	S 150	All exit signs are being replaced or fixed and will be put on a regular Maintence check for one week for a month and then monthly after that yearly. This all be done by 8/24/25 by maintence and then after that a monthly Q/A meeting will be done.	8/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Ross
TITLE: Admin
(X6) DATE: 8/15/25

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S 150	Continued From page 1 *Emergency light by resident room 114. Findings include: 1. Interview and testing of emergency lighting on 7/9/24 with administrator A revealed: *At 11:00 a.m. testing of the first floor C wing stairwell exit light revealed it would not illuminate when tested. -Administrator A confirmed the light would not illuminate when tested. *At 11:30 a.m. testing of the first floor B wing exit light by the kitchen revealed it would not illuminate when tested. -Administrator A confirmed the light would not illuminate when tested. *At 1:15 p.m. testing of the second floor A wing exit light by the commons revealed it would not illuminate when tested. -Administrator A confirmed the light would not illuminate when tested. *At 2:20 p.m. testing of the emergency light by resident room 114 revealed it would not illuminate when tested. -Administrator A confirmed the light would not illuminate when tested. *Administrator A stated that the emergency lighting was under the oversight of the maintenance manager. -The maintenance manager was out of the facility and not available for interview during the survey.	S 150		
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	S 165	Bed rails will have sleeves and be put on so there is not a wide gap in between for resident to be injured Nursing will make sure the sleeves are on the bedrails and have a daily service for the staff to ensure the sleeves are on the bed rails at	

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S 165	Continued From page 2 facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and care record review, the provider failed to ensure two of two sampled residents (2 and 10) who utilized a physical restraint had assessments and documentation to ensure continued safe use of them. Findings include: 1. Observation and interview on 7/9/25 at 9:50 a.m. in resident 10's room revealed a U-shaped assist bar was located on the outside of her bed. Resident 10 indicated she used the bar to assist herself to get in and out of the bed. Observation and interview on 7/10/25 at 10:45 a.m. in resident 10's room regarding the U-shaped assist bar revealed: *There was a thirteen and one-half inch gap between the bar which was large enough to fit a body part through. *The resident confirmed she had brought the assist bar from her home and her son-in-law had installed it on her bed. Review of resident 10's care record revealed there was no documentation an assessment for the assist bar had been completed to ensure it was installed and had been used safely. 2. Observation and interview on 7/9/25 at 10:45 a.m. in resident 2's room revealed a U-shaped assist bar was located on the outside of her bed. Resident 2 indicated she used the assist bar to get in and out of the bed.	S 165	times. This does include residents 2 and 10. Nursing has insured that additional residents have been identified and proper assessments have been or will be done by 08/24/25 Nursing will be responsible to assess residents safety. Staff education will be given by nursing on the imporatnace of the bed rails on 8/15/25. Nursing will do weekly audits for 4 weeks and then monthly for 6 months. Audit sheets will be reviewed by nursing and administration at a monthly Q/A	08/24/25

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S 165	Continued From page 3	S 165		

Observation on 7/10/25 at 9:20 a.m. in resident 2's room with registered nurse C regarding the U-shaped assist bar revealed there was a seventeen inch open gap between the bar which was large enough to fit a body part through.

Review of resident 2's care record revealed:
*An admission date of 11/22/24.
*Diagnoses of falls, left knee degenerative joint disease (arthritis), and history of a total left knee replacement.
*There was no documentation an assessment had been completed for the assist bar to ensure it was installed and used safely.

Interview on 7/10/25 at 10:30 a.m. with resident 2 regarding the U-shaped assist bar revealed her family had brought the assist bar in and had installed it on her bed.

3. Interview with administrator A on 7/10/25 at 7:55 a.m. and director of nursing B, who participated via telephone, regarding residents 2 and 10 revealed:
*They were not aware that both residents had an assist bar on their beds.
*They thought the residents' families had brought the assist bars in.
*They did not know a safety assessment for the use of a side rail or assist bar should have been completed.
*They had never completed safety assessments for the use of side rails or assist bars on beds.
*Residents 2 and 10 did not have an assessment completed for the safe use of a side rail or assist bar.
*They did not have a bed rail or assist bar policy.

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S 169	Continued From page 4	S 169		
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview and testing the provider failed to ensure: *Staff responded to door alarms from the C wing stairwell exit. *Audible door alarms for two of four doors (patio door and north exit) that exited from the east building were functioning. Findings include: 1. Testing on 7/9/25 at 10:30 a.m. of the door alarm from the C wing stairwell exit revealed: *The door was opened and should have triggered an alarm at the nurse station initiating a staff response to verify who left from the C wing stairwell exit. *After approximately one minute of waiting no staff member had responded or entered the C wing hall. *Walking towards the nurse station, the surveyor could not hear an audible alarm, nor did he see any staff. *After approximately three minutes and arriving at the nurse station there were no staff in the C wing hall nor an audible alarm at the nurse station.	S 169	We have planned a staff inservice and will be discussing the importance of checking the door alarms when they are going off. A policy and procedure has been written.This will be completed on 08/15/25 and policy will be reviewed during inservice. An audit will be done daily for 2 weeks then weekly for one month for 6 months then monthly ongoing. Nursing and administration will review the audit monthly. A monthly Q/A will be done. Management will be doing the daily audits	08/15/25

South Dakota Department of Health

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S 169	Continued From page 5	S 169		

Testing on 7/9/25 at 11:00 a.m. of the C wing stairwell exit door alarm with Administrator A confirmed a door alarm sounded at the nurse station when the exit door was opened.

Interview and testing on 7/9/25 at 2:30 p.m. of the door alarm from the C wing stairwell exit with Administrator A revealed:
*The door was opened and should have triggered an alarm at the nurse station, initiating a staff member response to verify who left from the C wing stairwell exit.
*Administrator A confirmed the audible alarm at the nurse station was initiated.
*After approximately one minute of waiting no staff had responded or entered the C wing hall.
*Walking towards the nurse station, the administrator confirmed she could not hear an audible alarm, or see any staff in the area.
*After approximately three minutes and arriving at the nurse station there were no staff in the C wing hall, nor an audible alarm at the nurse station.
*Administrator A interviewed staff and learned staff had heard the alarm.
*A unknown staff person silenced the alarm but did not go to the exit to verify if a resident had left from the exit door.
*Administrator A confirmed staff were to go to the exit and verify if a resident had left when the alarms sounded to ensure resident safety.

2. Interview and testing on 7/9/25 at 12:30 p.m. of the east building patio door exit alarm with Administrator A revealed:
*When the patio door was opened there was no audible alarm.
*Administrator A confirmed the door should have alarmed when the door was opened.
*Administrator A entered the code to bypass the

South Dakota Department of Health

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S 169	Continued From page 6 door alarm, and the audible alarm sounded. *Administrator A was not aware the alarm was not working correctly. *She agreed the alarm should have sounded when the door was opened to alert staff the exit door was being opened. 3. Interview and testing on 7/9/25 at 12:30 p.m. of the east building north exit door alarm with Administrator A revealed: *When the north exit door was opened there was no audible alarm. *Administrator A indicated when the door was opened the alarm should have triggered and an overhead chime should have sounded. Staff should then come to the door to reset the alarm at the door. *She agreed the north exit door alarm was not working.	S 169		
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: Based on record review, interview, and policy review, the provider failed to conduct fire drills one per shift per quarter over the length of a year.	S 201	We will be doing fire drills every month alternating shifts per our policy and procedures that are in place. The administrator will be responsible for making sure this is done. An audit will be done monthly to ensure these drills are being done correctly. A monthly Q/A will be done.	08/24/25

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S 201	Continued From page 7 Findings include: 1. Review of the fire drill records for the first two quarters of 2025 revealed: *Only one fire drill had been recorded in March 2025. *There was no documentation of fire drills being completed for all shifts at least once per quarter. Interview on 7/9/25 at 2:30 p.m. with administrator A revealed: *She was conducting one fire drill for only one shift per quarter. -Fire drills were not being conducted on each shift during the quarter. *She had misunderstood the policy and requirement and agreed they were not conducting one fire drill per shift per quarter. Review of the Fire drill policy revealed: *It was last reviewed in 3/2024. *"A fire drill is held on each shift at least once per quarter. Per state regulations, resident evacuation must be completed and timed."	S 201	Administration will audit all meetings and staff attendance.	
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review and interview, the provider failed to ensure ongoing annual education was provided on the required subjects	S 295	A new inservice sign-in sheet has been created to track those who have attended, were absent, and for those that received written training information, including date and signature. See attached. New Powerpoint training information was printed off for letters B, D, J and will be completed by 08/15/25. Administration and other department heads will make sure all signatures are received during inservices.	08/15/25

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S 295	Continued From page 8 for four of four sampled employees (B, D, J, and K) for one of the eleven personnel training topics. Findings include: 1. Review of employee B's personnel file revealed: *A hire date of 8/5/2005. *She was the director of nursing. *There was no documentation she had received the required annual training on abuse and neglect. 2. Review of employee D's personnel file revealed: *A hire date of 12/7/21. *She was a certified medication aide. *There was no documentation she had received the required annual training on abuse and neglect. 3. Review of employee J's personnel file revealed: *A hire date of 5/29/02. *She was a cook. *There was no documentation she received the required annual training on abuse and neglect. 4. Review of employee K's personnel file revealed: *A hire date of 11/16/23. *She was a resident assistant. *There was no documentation she received the required annual training on hospice. 5. Interview on 7/10/25 at 1:58 p.m. with administrator A regarding the required staff revealed they should have completed the required annual training topics, but the above employees had not.	S 295	Administration will audit all meetings and staff attendance. A monthly Q/A will be done	

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S 296	Continued From page 9	S 296		
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; (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	S 296	Employee E was actually at the hospice inservice and Employee I no longer is employed by Countryside Living. Employee K will be given hospice education information and it will be completed by 08/15/25. Administrator will monitor to make sure training is being completed within the 30 days of hire. A monthly Q/A will be done	8/24/25

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S 296	Continued From page 10 met as evidenced by: Based on employee personnel file review and interview, the provider failed to ensure the required training was completed within 30 days of hire for two of two newly hired sampled employees (E and I) for one of the eleven personnel training topics. Findings include: 1. Review of employee E's personnel file revealed: *A hire date of 11/6/24. *She was a certified medication aide. *There was no documentation that she had completed the required training within 30 days of hire regarding education based on the residents' care needs (hospice). 2. Review of employee I's personnel file revealed: *A hire date of 11/6/24. *She was a cook. *There was no documentation that she had completed the required training within 30 days of hire regarding education based on the residents' care needs (hospice). 3. Interview on 7/10/25 at 1:58 p.m. with administrator A regarding employee training revealed employees E and I had not completed education based on the residents' care needs (hospice) within 30 days of hire and should have.	S 296		
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.	S 315	New forms will be made out if the resident will be receiving the flu shot at Countryside Living every fall. Audits will be done by the Administration and will review 4 charts weekly and will be completed	08/24/25

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S 315	Continued From page 11 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 care record review, interview, and policy review, the provider failed to document an influenza vaccination or its refusal for one of six sampled residents (4). Findings include: 1. Review of resident 4's care record revealed he had an admission date of 10/26/23. There was no documentation of either the resident's refusal or an influenza vaccination being given during the 2024 or 2025 influenza seasons. Interview on 7/10/25 at 1:50 p.m. with administrator A regarding resident 4 confirmed there was no documentation for the influenza vaccination being given or refusal of the influenza vaccination during the 2024 or 2025 influenza seasons. Review of the provider's June 2024 Flu Vaccination policy revealed: *"1. All employees and residents will be offered the opportunity to receive a flu vaccination every fall. *2. Employees and residents are informed/educated of the benefits and potential side effects to themselves and to those around them if they are protected. *3. If an [a] resident refuses the vaccination on the date established by the facility, they will need to sign [a] consent form for the refusal. *4. The vaccine will be administered by [pharmacy name]."	S 315	by 08/24/25 and then ongoing 2 per week for one month and at on admission. Nursing will ensure consent forms are signed on admission and yearly for Influenza, Pneumonia and COVID immunizations. Administration will audit files on admission and yearly. A monthyl Q/A will be done	08/24/25

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S 320	Continued From page 12	S 320		
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 care record review, interview, and policy review, the provider failed to document a pneumonia vaccination or its refusal for two of six sampled residents (4 and 6) within fourteen days of their admission. Findings include: 1. Review of resident 4's entire care record revealed he had an admission date of 10/26/23. There was no documentation of his pneumonia vaccination or refusal. 2. Review of resident 6's entire care record revealed she had an admission date of 3/28/25. There was no record that the pneumonia vaccine was offered to her or that she had signed a refusal form for that vaccine in the electronic medical record. 3. Interview on 7/10/25 at 1:50 p.m. and 2:55 p.m. with administrator A regarding residents 4 and 6 revealed: *She confirmed there was no documentation for the pneumonia vaccination or refusal. *The nurse would have been responsible for ensuring this vaccination was completed.	S 320	Residents will sign consent forms on admission and again yearly for COVID and influenza. Pharmacy sets up a shot clinic for COVID, Influenza on a yearly basis. Nursing will have all consent forms signed. Administration will audit to make sure these forms are signed at admission and yearly. Residents 4 and 6 will have signed their consent forms by 08/24/25 for all immunizations.	08/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49893	A. BUILDING: ____ B. WING ____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	**2100 N WISCONSIN MITCHELL, SD 57301**

(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 320	Continued From page 13 4. Review of the provider's June 2024 Pneumonia Vaccination policy revealed: *"1. All residents will be offered the opportunity to receive a pneumonia vaccination. *2. Residents are informed of the benefits to themselves and to those around them if they are protected. -The pneumonia vaccination is needed only every 7-10 years. -Check with your physician. *3. If a resident refuses the vaccination on the date established by the facility for residents to receive them, they will need to sign [a] paper that they decline the vaccination. *4. The vaccine will be administered by the resident's clinic of choice."	S 320		
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	S 331	A new checklist has been made for when our residents go from independent to assisted. Residents will get TB test within the set timeline after admission. All paperwork will be in the admission file. Checklist will also include everything needed for admission for assisted living and if they transition from independent to assisted. Administration and nursing will be responsible for the checklist. TB policy and procedure will be advised or updated by 08/24/25.	08/24/25

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
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

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S 331	Continued From page 14 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 the two-step tuberculin (TB) screening was completed within twenty-one days of admission for two of six sampled residents (2 and 6). Findings include: 1. Review of resident 2's care record revealed: *Her admission date was 11/22/24. *There was no documentation that indicated the two-step TB screening test had been completed. 2. Review of 6's care record revealed: *Her admission date was 3/8/25. *There was no documentation that indicated the two-step TB screening test had been completed. 3. Interview on 7/10/25 at 1:50 p.m. and 2:55 p.m. with administrator A regarding the TB screenings for residents 2 and 6 revealed they had not been	S 331	Our audit will include our checklist that will be signed during admission and hiring comp[leted by 08/24/25 that will be done by nursing and administration A monthly Q/A will be done	08/24/25

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
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

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S 331	Continued From page 15 completed within the required twenty-one day time frame from their admission date and should have been. 4. Review of the provider's undated Infection Control & Prevention policy regarding Mantoux (tuberculin skin test that determines if a person had been infected with tuberculosis) Testing revealed: *"Policy statement: ...all assisted living residents will have a two-step Mantoux within 21 days of admission/hire of admission unless one was completed within 6 months of admission to the residence."	S 331		
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: A. Based on observation, care record review, and interview, the provider failed to ensure one of one sampled resident (4) who was at risk for and had developed a pressure ulcer had ongoing assessments, documentation, prevention measures, and treatment interventions in place to heal a pressure ulcer and prevent further skin breakdown. Findings include: 1. Observation and interview on 7/10/25 at 8:35 a.m. in resident 4's room revealed he: *Was sitting in his recliner.	S 337	A policy was written for any skin issue. Nursing will assess weekly to maintain residents integrity. A skin identification sheet has been made. Nursing has educated staff on how to fill out sheets and will be completed by 08/24/25. Nursing will be documenting weekly skin assessments on the EMAR and will be contacting Doctors and family. A monthly Q/A will be done.	08/24/25

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
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

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S 337	Continued From page 16	S 337		

*Was alert and oriented.
*Had a "sore bottom and staff would put salve [type of wound care treatment] on it."

Review of resident 4's care record revealed:
*He had been admitted on 10/26/23.
*His diagnoses included atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), chronic kidney disease stage four, and osteoarthritis (pain and stiffness in joints) of his left knee.
*He had a history of falls and had been seen by physical therapy.

Review of resident 4's progress notes revealed:
*On 5/19/25 at 11:55 a.m. director of nursing (DON) B documented: "Resident was noted to have a [an] open area to his Lt [left] butt cheek. No bleeding was noted. Was unable to find his Medi honey [Medihoney, a wound care product]at this time. so dressing was applied to [the] area. Will remind him daily to lay [lie] on his side when he is resting in bed. Will update family and Dr [doctor]."
*On 6/1/25 10:10 p.m. certified medication aide (CMA) G documented: "The bandage from his wound came off so that will need to be redressed tomorrow morning."
*On 6/2/25 at 9:43 a.m. registered nurse (RN) F documented: "Pressure ulcer L inner buttock: -Pressure ulcer noted to L inner buttock. No drainage, slightly red. Area is 1/4 [one-quarter] cm (centimeter) with redness around [the] open are [area]. Rt [right] inner buttock is also red. Fax sent to wound care advising them of this."
*On 6/2/25 at 10:23 a.m. RN F documented: "Phone call received from wound care. They request that RN contacts primary care Dr for orders and they will see resident if primary care provider requests it. Fax sent to [physician's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49893	A. BUILDING: ________ B. WING ________	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

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S 337	Continued From page 17	S 337		

name] office with a description of the wound."
*On 6/5/25 at 10:22 a.m. CMA H documented: "When MA (medication aide) removed the bandage from the resident's sore, as directed to apply the ointment, the MA noted brownish discharge on the bandage and a foul smell."
*There were no further entries regarding the pressure ulcer to resident 4's left inner buttock and no follow-up documentation that indicated the physician or nurse had been notified.

Review of resident 4's physician's orders revealed an order on 6/3/25 that directed "A&D ointment apply daily to wound."

Review of resident 4's medication administration record and treatment administration record for May 2025 and June 2025 revealed:
*May 2025:
-Petroleum Jelly 3.75 ounce (daily) apply topically to wound one time daily. (Order to end on 6/23/25)
--Five times it had been documented as not completed.
*June 2025:
-Two times it had been documented as not completed (prior to it ended on 6/23/25).

Continued review of resident 4's care record revealed:
*There was no documentation that the pressure ulcer identified on 6/2/25 had ongoing assessments completed by nursing.
*There was no documentation that the nurse or the physician had been notified of the brown drainage and foul smell that was indicated on 6/5/25 by CMA H.
*The resident's service plan had not been updated regarding the left buttock pressure ulcer.
*There was no further documented follow-up to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

(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 18	S 337		

the physician after 6/3/25 regarding the left buttock pressure ulcer.
*There was no documentation that indicted a licensed nurse had seen or assessed the left buttock pressure ulcer following 6/2/25.

Interview on 7/10/25 at 7:55 a.m. with administrator A and DON B, who joined via telephone, regarding resident 4's pressure ulcer revealed:
*The CMAs had been applying skin barrier cream [A&D ointment] to his bottom daily.
*Nursing had not followed up with the resident's physician after the 6/5/25 progress note entry regarding the wound having a foul smell and brown drainage.
*Nursing did not do "skin sheets" or specific documentation for wounds.
*If there was no documentation in his care record regarding follow-up, then it had not been done.
-They agreed that it should have been followed up on.
-They were not sure if the part-time RN had followed-up on the resident's wound or the 6/5/25 note about the foul smell and brown drainage.
*DON B:
-Had said a CMA had contacted her regarding discontinuing the resident's A&D ointment.
-Did not want to discontinue the resident's A&D ointment because she wanted to use it as a protective barrier.
-No nurse had checked resident 4's buttock to see if it had healed.
-CMAs should not have been determining if a treatment should be discontinued.
*CMAs had applied the A&D ointment to resident 4's buttock area.

Interview on 7/10/25 at 8:58 a.m. with RN C revealed:

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
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

(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 19	S 337		

*She worked one to two days a week at the facility.
*She completed tasks assigned to her by DON B.
*The licensed nurses did not complete routine skin assessments for residents.
*The CMAs would report any skin issues following a resident's shower to the nurse.
*The licensed nurses did complete an initial skin assessment when a resident was admitted, but no further skin assessments were completed.
*She had not followed-up on resident 4's left buttock pressure ulcer.
*She thought DON B had called "wound care" and they were using Medihoney to the pressure ulcer.
*She agreed a nurse should have followed-up on the 6/5/25 entry regarding resident 4 having brown drainage and a foul smell to the left buttock area.
*There had been no follow-up by a nurse.
*A CMA had told DON B the area had been healed, wanted the A&D discontinued, but DON B didn't want it discontinued.
*She agreed that a nurse should have looked at a wound before a treatment was discontinued.
*She agreed it was out of the scope of practice for a CMA to make a judgement call regarding treatments being discontinued.

Observation and interview on 7/10/25 at 9:10 a.m. with RN C in resident 6's room revealed he had company at that time and refused to have his bottom assessed.

Interview on 7/10/25 at 9:30 a.m. with administrator A revealed they did not have a skin/wound policy.

B. Based on care record review, interview, and

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49893	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

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S 337	Continued From page 20 policy review, the provider failed to investigate a fall with a serious injury for one of one closed resident (1) record reviewed to verify that no abuse or neglect had occurred. Findings include: 1. Review of resident 1's care record revealed: *She was admitted on 1/24/25. *Her diagnoses included chronic obstructive pulmonary disease (long-term lung disease characterized by breathlessness) , metabolic encephalopathy (brain function disrupted by disturbance in metabolic function), hypertension (high blood pressure), heart failure, and osteopenia (reduction in bone mineral density). *A Saint Louis University Mental Status (SLUMS) assessment completed at the time of her admission revealed a score of twenty-two out of thirty, which indicated the resident had a mild neurocognitive disorder. *She used a walker for ambulation but was not always compliant with its use. Continued review of resident 1's care record revealed: *She fell, unwitnessed, on 1/30/25 at approximately 5:30 a.m. in her room. -When staff found her, she was unable to tell them what she was doing or how long she had been on the floor. -That fall resulted in no serious injury. -The follow-up documentation indicated that the resident would have two-hour checks during the night to ensure she was safe in her bed. *Her undated care plan indicated that a new intervention was implemented on 1/30/25 at 8:03 a.m. that stated was to have safety checks at 1:00 a.m., 3:00 a.m., and 5:00 a.m. each day. *She fell again, unwitnessed, on 1/31/25 at approximately 5:30 a.m. in her room.	S 337	Nursing will complete an investigation regarding any serious injuries. Findings will be found on the incident report. Our investigation policy and procedures will be created and completed by 08/24/25. Nursing will follow-up with evaluations and administration will follow up after nursing. A monthly Q/A will be done	08/24/25

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
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 337	Continued From page 21 -Her progress note indicated that she was found on the floor and told staff she wanted to lie there because it was warm. -The task review area of her record was not accessible for events prior to the middle of April 2025 to review documentation. -The resident was transferred to the emergency room for evaluation several hours later regarding her complaints of left hip pain. -The follow-up documentation did not provide information related to what had occurred before, during, or after her 1/31/25 fall. There was no indication of who had been interviewed or any investigation that had occurred related to her fall. *She was admitted to the hospital for a fracture of her left hip on 1/31/25. -Upon discharge from the hospital on 2/4/25, she was transferred to a long-term care facility and passed away on 2/11/25. Interview on 7/10/25 at 12:00 p.m. with administrator A regarding resident 1 and her history of falls revealed: *The resident's falls occurred while the administrator had been out of the facility and on vacation. *Director of nursing (DON) B was to have led an investigation into the fall and completed a reportable event to the South Dakota Department of Health if it was warranted. -DON B was out of the facility and unavailable for interview during this portion of the survey. *Administrator A agreed that the information that had been presented to the surveyor and in the resident's record did not show that an investigation into the resident's fall had occurred. *She was unable to state if abuse or neglect had occurred due to the lack of investigation into the resident's fall.	S 337		

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
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S 337	Continued From page 22 Review of the provider's March 2024 Resident Safety Policy - Falls revealed, "8. Need to chart summary in the residents [resident's] progress notes." Review of the provider's July 2022 Resident Safety Policy - Abuse, Fraud, and Wrongdoing did not provide guidance on when or how an investigation was to be conducted.	S 337		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. 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 six sampled resident (6) had been evaluated for her care needs after she had resided in the facility for 30 days. Findings include: 1. Review of resident 6's electronic medical record (EMR) revealed there was no documentation that indicated care needs had been evaluated after being in the facility for 30 days according to the requirement. 2. Phone interview on 7/10/25 at 7:54 a.m. with DON B regarding resident 6's admission on 3/28/25 revealed: *DON B stated that resident 6 did not have a	S 352	Staff will continue to be educated on the confidentiality of each one of our residents. A monthly Q/A will be done	

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
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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 352	Continued From page 23 30-day evaluation completed. *She stated it had not been done because the admission record had been put into her electronic medical record (EMR) incorrectly under the wrong category, and it had not triggered for that 30-day evaluation to be completed. 3. Review of the provider's Admission & Move In policy dated 6/2024 and titled "Ongoing Residents Assessments" revealed: *"Procedure: 2. One - Month Resident Assessment" -"A. Resident will be formally assesses [assessed] thirty days after admission, B. The administrator or RN [(registered nurse)] will meet with the resident and/or responsible party to verify the resident's needs are met."	S 352	Nursing and Administration will monitor and make sure that a date will be put in the Rtask system for a 30 day assessment to be reviewed at a timely matter. A Q/A will be done monthly	8/24/25
S 775	44:70:09:02 Facility To Inform Resident Of Rights Prior to or at the time of admission, a facility shall inform the resident, both orally and in writing, of the resident's rights and of the rules governing the resident's conduct and responsibilities while living in the facility. The resident shall acknowledge in writing that the resident received the information. During the resident's stay the facility shall notify the resident, both orally and in writing, of any changes to the original information. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure an acknowledgement of receipt for a copy of the resident's rights had been signed and dated by two of six sampled residents (1 and 6) or their representatives. Findings include:	S 775	The resident rights are in the Resident Manual and have been added to the agreement. The residents will also receive educational information upon admission. A policy and procedure has been written. A monthly Q/A will be done	8/24/25

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
	49893	A. BUILDING: ______ B. WING ______	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

(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 775	Continued From page 24 1. Review of resident 1's closed care record revealed: *She was admitted on 1/24/25 and discharged on 1/31/25. *There was no documentation that the resident or her representative had signed an acknowledgement that they had received a copy of the resident's rights prior to or at the time of her admission. 2. Review of resident 6's care record revealed there was no documentation that indicated she had been educated of her rights prior to or when she had admitted to the facility. 3. Interview on 7/10/25 at 12:00 p.m. and 2:55 p.m. with administrator A revealed: *There was no documentation that residents 1 and 6 had been educated on or had signed a copy acknowledging receipt of their rights when they admitted to the facility. *She was not aware of the regulation required that an acknowledgment of the resident rights and responsibilities be addressed upon their admission. *She followed the admission process that had been taught to her by staff who were no longer associated with the organization. *There was no policy related to the resident's or their representative's acknowledgement of receiving education on or a copy of the resident's resident rights and responsibilities.	S 775		
S 820	44:70:09:08 Privacy And Confidentiality A facility shall provide for privacy and confidentiality for the resident. This Administrative Rule of South Dakota is not	S 820	Staff will continue to be educated on the confidentiality of each one of our residents. A audit sheet will be drafted for both building and reviewed by nursing and administration. A Q/A will be done at our monthly manager meetings.	08/24/25

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	**2100 N WISCONSIN MITCHELL, SD 57301**

(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 820	Continued From page 25	S 820		

met as evidenced by:
Based on observation, interview, and agreement review, the provider failed to provide confidentiality for five of five random residents (4, 6, 7, 8, and 9) by two of two certified medication aides (CMA) (D and E) while at the medication carts located in the facility lobby during six of six observations.
Findings include:

1. Observation on 7/9/25 between 11:50 a.m. and 12:04 p.m. with CMA D revealed:
*There were two medication carts located in the front lobby.
*She was utilizing the computer located on the left medication cart to access the residents' electronic medication administration records.
*At 11:50 a.m. she stepped away from the cart to administer medications to resident 4.
-The computer screen was left open to that resident's medication list while the cart was unattended.
*At 11:58 a.m. she stepped away from the cart to administer medications to resident 7.
-The computer screen was left open to that resident's medication list while the cart was unattended.
*At 12:01 p.m. she stepped away from the cart to administer medications to resident 6.
-The computer screen was left open to that resident's medication list while the cart was unattended.
*At 12:04 p.m. she stepped away from the cart to administer medications to resident 8.
-The computer screen was left open to that resident's medication list while the cart was unattended.
*Each time she left the computer screen open with resident information it was visible to other residents, staff, and visitors that were in the lobby

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE LIVING	2100 N WISCONSIN MITCHELL, SD 57301

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S 820	Continued From page 26	S 820		

area at that time.
*There were multiple staff and residents walking through the lobby during that time.

Observation and on 7/9/25 between 12:41 p.m. and 12:45 p.m. of the computer screen on the medication cart located to the left revealed the screen was open to the medication list of an unknown resident and visible to the other residents, staff, and visitors in the area.

Interview on 7/9/25 at 12:45 p.m. with CMA D revealed:
*She stated that she usually closed the computer or minimized the screen when walking away from it.
*She acknowledged that she had left it open and unattended for several minutes before she returned to the cart and that private information was visible to others.
-She stated that it was because she had to rush and catch a resident's family member.
*She did not offer information related to leaving the residents' information visible during the earlier observations.

2. Observation on 7/9/25 at 4:30 p.m. of the two medication carts in the front lobby revealed:
*The computer screen on the medication cart located to the left was open to resident 9's medication administration record.
*There were no staff in the area.
*CMA E had been assigned to the medication cart during that time.

3. Interview on 7/10/25 at 12:35 p.m. with administrator A regarding resident privacy and confidentiality revealed:
*She agreed the computer should not have been left unattended with resident information visible.

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S 820	Continued From page 27 *It was her expectation that confidential resident information was not visible on an unattended computer screen. *There was no policy regarding confidentiality; however, a confidentiality agreement was provided to all employees. 4. Review of the provider's undated HIPAA Employee Confidentiality Agreement revealed "4. Charts and Records. Confidential and Medical information is maintained in files for residents of this Healthcare Facility in the form of paper and/or electronic documents. Any and all such records are considered confidential and shall not be left unattended..."	S 820		