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
	10687	A. BUILDING: _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY CORNER	19566 OLDE BELLE ROAD SPEARFISH, SD 57783

Sarah Allbright, Administrator 10/24/2024
signature of adminstrator

(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 Surveyor: 40788 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 9/16/24 through 9/17/24. Serenity Corner was not in compliance with the following requirements: S165, S201, S285, S337, S352, S443, S630, S633, S670, S685, and S782 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 9/16/24 through 9/17/24. The areas surveyed included resident rights and quality of life. Serenity Corner was found in compliance.	S 000		
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. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on observation, record review, interview, and policy review, the provider failed to: *Operate in a manner to avoid injury or danger to the five of five residents (3, 5, 7, 8, and 9) who smoked. *Implement their No Smoking policy.	S 165	S165 Facility administrator updated No Smoking policy to "Smoking Policy and Procedure" effective 10/30/2024. The policy has been updated to reflect goal of facility to become no smoking facility at future date with residents admitting to be notified of this goal as well as outlines current smoking policy including details of safety of residents/facility and includes designated smoking times to ensure resident safety. In addition policy covers in place smoking assessment completed as follows as part of resident care plan: Care plan including smoking assessment during admit regarding residents ability to safety smoke as well as personal goals for smoking, including cessation options/ interventions if interested. This is completed by administrator/designee & Facility Contracted RN during admission, 30 day and annually as well as reviewed/ updated as needed when resident observed to have change in level of care, needs/ safety concerns or also if resident identifies change in goals for smoking for self. Residents who elect to smoke will also continued to be monitored by staff and facility RN to assess for changing ability to safety smoke, including monitoring for burns, holes in clothing, unsafe smoking practices. If noted to be reported to administrator and facility contracted RN for further assessment as this has been current facility practice. Facility administrator is responsible to audit care plans for residents who smoke every 6 months to ensure compliance with above for one year. This audit is maintained in audit binder.	10/30/2024

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

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S 165	Continued From page 1 Findings include: 1. Observation on 9/16/24 at 8:15 a.m. of resident 5 revealed she sat unsupervised in a chair on the walkway to the provider's main entrance and was smoking. Observation on 9/16/24 at 8:30 a.m. of the attached outdoor porch near the kitchen revealed: *Three to four residents were seated on the porch smoking and unsupervised. *Posted signage inside of the facility next to the porch door: -Identified six designated smoking times. -"Smoking is a Privilege! Smoking can be taken away for failure to follow these rules." Interview on 9/16/24 at 9:00 a.m. with manager/unlicensed medication aide C revealed: *Residents 3, 6, 8, 9, and 10 smoked. *Smoking materials for all but one of those residents were kept by staff and were dispensed to the resident at designated smoking times. Review of the Resident Admission Packet and the Policy and Procedure manual last reviewed and revised by administrator A on 2/2/24 revealed: *They both contained a "No Smoking Policy" form. -"Serenity Corner is a non-smoking facility both inside the facility and outside. This is to ensure the safety of both the residents and employees." -A line for the resident or their representative to sign acknowledging their understanding of the policy. -A staff signature line. Interview on 9/17/24 at 1:45 p.m. with administrator A regarding resident smoking revealed:	S 165		

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S 165	Continued From page 2 *Her goal was for the facility to become a non-smoking facility but it currently was not. *The No Smoking Policy was not consistent with the current practice of allowing residents to smoke. *There was no standardized checklist that was regularly administered and assessed a smoking resident's ability to safely smoke or continue to smoke. -Unsafe smoking practices by residents and observed by staff were reported to her for follow-up.	S 165		
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: Surveyor: 18087 Based on observation and interview, the provider failed to provide egress doors as required at four of four locations (marked exit doors). Findings include: 1. Observation on 9/17/24 beginning at 3:30 p.m. revealed the four exterior exit doors for the building were equipped with magnetic lock hardware. Interview at the time of the observation	S 201		

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S 201	Continued From page 3 with administrator A confirmed that condition. She stated the magnetic locks would be activated by a Wanderguard device so the doors would lock and not be able to be opened without entering a code on the keypad next to the door or moving the resident with the Wanderguard tag away from the door. She further stated the magnetic locks would release upon activation of the fire alarm system and could be tested during the monthly fire drills. She stated the doors were not delayed egress-type magnetic locks that would allow egress during emergencies other than fire incidents. She further stated the magnetic locks had been on the doors for many years and had not been cited in the past as being non-compliant. Reference NFPA 101 LSC, 2012 Edition, Existing Residential Board and Care Occupancies, Small Facilities, Section 33.3.2.2.2 Doors. Doors in Means of Egress shall be as follows: (3) No door in any means of egress, other than those meeting the requirement of 33.3.2.2.2(4) or (5), shall be locked against egress when the building is occupied. (4) Delayed-egress locks in accordance with 7.2.1.6.1 shall be permitted. (5) Access-controlled egress doors in accordance with 7.2.1.6.2 shall be permitted.	S 201	S201 Administrator had updated system to include use of delayed egress setting on wander guard system no later than 10/30/2024. Doors are now in compliance with NFPA 101 LSC (33.3.2.2.2 Doors.) Facility administrator verified operation of all doors on 10/25/2024 to ensure delayed-egress function is operational.	10/30/2024
S 285	44:70:04:03 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Personnel on duty must be awake at all times, except as provided in § 44:70:03:02.01. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and	S 285		

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S 285	Continued From page 4 services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or personnel on contract. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on personnel file review, interview, and policy review, the provider failed to implement a pre-employment screening process to ensure they had not knowingly hired any person with an abuse conviction for five of five sampled employees (C, D, E, F, and G). Findings include: 1. Review of personnel files revealed : *Employee C's hire date was 6/8/22. *Employee D's hire date was 1/14/24. *Employee E's hire date was 8/1/24. *Employee F's hire date was 6/9/22. *Employee G's hire date was 2/2/23. -There was no documentation to support a background check was completed before any of these employees were hired. Interview on 9/17/24 at 12:30 p.m. with administrator A regarding the facility's pre-employment screening process revealed: *Background checks were not a part of that process. -Initiating pre-employment background checks was on her "To Do" list. Review of the provider's policy and procedure manual last reviewed and revised by administrator A on 2/2/24, job descriptions, and personnel-related polices revealed there was no mention of a pre-employment screening process	S 285	S285 Administrator will complete background checks for all current employees as well as include background check as part of pre-employment screening process for new hires immediately. As of 9/27/2024 background screening materials have been ordered (finger print cards) with expectation for all current employees to complete card within 2 weeks of arrival no later than 10/31/2024 with arrangements made for fingerprinting to be completed at Meade County Jail as verified with DCI. Fingerprint cards to be mailed for processing by no later than November 1. 2024. Background check to be completed as pre-employment screening process and Administrator update by10/3/2024 to reflect this updated policy/ procedure for staffing to include this change. In addition facility will continuing current processes of pre-employment screening which include application, directly inquiring about history of abuse/neglect charges and during verification of professional references including screening for past abuse/neglect charges.	10/31/2024

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S 285	Continued From page 5 that included a background check for abuse.	S 285		
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: Surveyor: 40788 Based on observation and interview, the provider failed to ensure: *One of one unlicensed medication aide (UMA) (C) who primed an insulin pen and dialed the insulin dose for one of one sampled resident's (1) insulin administration received unlicensed diabetic aide (UDA) training before performing those tasks. Findings include: 1. Observation and interview on 9/16/24 at 11:45 a.m. with UMA C as she prepared resident 1's insulin pen for self-administration revealed she: *Primed the pen then turned the dial of the pen to "6" units. *Handed the pen to the resident after the resident wiped her abdomen with an alcohol pad. *Resident 1 inserted the insulin pen needle into her abdomen, pushed the dose button, and administered the insulin. *UMA C had not completed the UDA training program. Interview on 9/17/24 at 12:55 p.m. with administrator A regarding the above observation	S 337	S337 Administrator to ensure all UMA staff have completed UDA training including 5 hours theory and 5 hours clinical as provided by DOH BON and Facility Contracted RN respectively prior to Oct 30, 2024. In addition all UMA must pass UDA test as provided by SD BON prior to Oct 30, 2024. During October monthly staff meeting Facility Contracted RN will review UDA training with all UMA staff and complete documentation to delegate this task to be maintaining in staff training binder. Moving forward all staff will receive UMA training to include UDA education requirements at a minimum upon hire and annually. Copies of this will be retained in staff training binder for each UMA and reviewed (audited) annually by facility administrator to ensure compliance.	10/30/2024

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S 337	Continued From page 6 revealed she: *Confirmed none of the facility's UMAs were UDA certified. -Thought UDA certification applied only to home health aides.	S 337	S352 Administrator and Contacted Facility RN have discussed and updated agreement to include the following practices/expectations. Facility Contracted RN in addition to initial full assessment will also preform reassessment 30 day and at minimum annually or following significant change in condition/medical status. Contracted Facility RN to perform 30 day reassessment for each resident as well maintain current practice which is for resident to be assessed by PCP within 30 days of admission. and at minimum annually. Full assessment by Facility Contracted RN to include assessment of the following: -Nursing care needs. -Medication administration needs. -Cognitive status as shown by tasks performed routinely by the resident such as self-administration of medications, telephone use, handling finances, use of transportation, managing life situations. -Mental health status. including cognitive assessment to be performed upon admission, 30 day and annually. -Physical abilities including activities of daily living, ambulation, and the need for assistive devices. -Dietary needs. Administrator will conduct chart audit , monthly and annually for each resident to ensure completion of all 3 nursing assessments (initial, 30 day, and annual) and maintain record of this in audit binder through 2025 with Administrator to audit charts every 6 months from then on and maintain audit log in audit binder. Facility administrator and facility contracted RN to ensure all records are up to date before Oct 30, 2024.	
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: Surveyor: 40788 Based on record review, interview, and review of the registered nurse (RN) service agreement, the provider failed to: *Evaluate and document resident care needs upon admission for one of four sampled residents (4). *Evaluate and document resident care needs thirty days after admission for four of four sampled residents (1, 2, 3, and 4). *Evaluate and document resident care needs annually for two of four sampled residents (2 and 4). Findings include: 1. Review of resident 1's care record revealed: *She was admitted on 6/27/24. *Her initial evaluation of care needs was completed on 6/30/24. *There was no documentation to support her thirty-day evaluation of care needs was	S 352		10/30/2024

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S 352	Continued From page 7 completed. 2. Review of resident 2's care record revealed: *He was admitted on 8/16/23. *His initial evaluation of care needs was undated. *There was no documentation to support his thirty-day and annual evaluations of care needs were completed. 3. Review of resident 3's care record revealed: *He was admitted on 2/26/24. *His initial evaluation of care needs was completed on 2/27/24. *There was no documentation to support his thirty-day evaluation of care needs was completed. 4. Review of resident 4's care record revealed: *She was admitted on 8/2/23. *There was no documentation to support her initial, thirty-day, and annual evaluations of care needs were completed. Interview on 9/17/24 at 2:45 p.m. with administrator A regarding the evaluation and documentation of resident care needs revealed: *RN B was expected to complete an initial resident care needs evaluation. -She considered the weekly resident progress notes completed by the medical provider to have met the criteria for thirty-day and annual evaluations of resident care needs. *The content of the medical provider's progress notes failed to address the following expectations of a resident care evaluation: -Nursing care needs. -Medication administration needs. -Cognitive status as shown by tasks performed routinely by the resident such as self-administration of medications, telephone use,	S 352		

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S 352	Continued From page 8 handling finances, use of transportation, managing life situations. -Mental health status. -Physical abilities including activities of daily living, ambulation, and the need for assistive devices. -Dietary needs. Review of the 5/15/24 service agreement between RN B and the provider revealed: *Responsibilities of RN B included "3. 30 day after new admission, reassess each new resident, document that needs are identified and being met including the audit of resident care plan." -There was no reference in that agreement regarding the expectation for the completion of an initial or annual evaluation of resident care needs.	S 352	S443 This was addressed above as part of initial, 30 day and annual full nursing assessments to be completed by Facility Contracted RN which has been updated 9/30/2024 to include expectation for cognitive screenings to be completed during full nursing assessments including initial, 30 day and annual as well as significant change in condition being noted. Facility Contracted RN agreement updated to include this expectation as of 9/27/2024.	
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on record review, interview, and review of the registered nurse (RN) service agreement, the provider failed to ensure: *One of four sampled residents (3) had an initial cognitive screening completed. *Two of two sampled residents (2 and 4) had an annual cognitive screening completed. Findings include:	S 443	Audit for cognitive screenings to be performed by facility administrator monthly and annually for each resident to ensure completion of all 3 nursing assessments (initial, 30 day, and annual) and maintain record of this in audit binder through 2025 with Administrator to audit charts every 6 months from then on and maintain audit log in audit binder. Facility administrator and facility contracted RN to ensure all records are up to date before Oct 30, 2024.	10/30/2024

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S 443	Continued From page 9 1. Review of resident 2's care record revealed: *He was admitted on 8/16/23. *There was no documentation to support an annual cognitive screening was completed. 2. Review of resident 3's care record revealed: *He was admitted on 2/26/24. *There was no documentation to support an initial cognitive screening was completed. 3. Review of resident 4's care record revealed: *She was admitted on 8/2/23. *There was no documentation to support an annual cognitive screen was completed. Interview on 9/17/24 at 2:45 p.m. with administrator A regarding cognitive screening expectations revealed: *RN B was expected to complete an initial resident care needs evaluation that included a cognitive screening. -There was no expectation of her to have completed cognitive screenings annually or if a resident had a significant change in their cognitive status. Review of the 5/15/24 service agreement between RN B and the provider revealed: *Responsibilities of RN B included "3. 30 day after new admission, reassess each new resident, document that needs are identified and being met including the audit of resident care plan." -There was no reference in that agreement regarding the expectation for completion of initial, annual, or significant change in cognition screenings.	S 443		

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S 630	Continued From page 10	S 630		
S 630	44:70:07:04 Storage And Labeling Of Medications All medications must be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight degrees centigrade. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to ensure one of one medication refrigerator was secured and maintained at a consistent and acceptable temperature. Findings include: 1. Observation on 9/16/24 at 9:00 a.m. in the kitchen revealed: *The medication refrigerator sat on top of the side-by-side refrigerator and was unsecured. -A chair was used by staff to stand on to access the refrigerator. -The medication refrigerator was slid forward above the top of the side-by-side refrigerator door to enable staff to open it. *On top of the side-by-side refrigerator next to the medication refrigerator was a prescription labeled box containing suppositories. *The underside of the freezer compartment inside of the medication refrigerator was covered with	S 630	S630 Facility administrator Oct 3, 2024 will purchase and install security device (hasp lock and combination/keyed lock) for medication refrigerator as well as move location of fridge for ease of access by UMA staff. Administrator will also conduct monthly audit of medication fridge contents and maintain this audit log in audit binder auditing fridge to ensure all medications stored are properly labeled with the following: Each original prescription container must be labeled with the resident name, drug name, strength, prescribers name, directions for use, prescription dispense date and expiration date. Also expiration dates to be checked during monthly audit any expired medication to be destroyed per facility policy/procedures. Copy of audit to be maintained in facility audit binder. Administrator as of 10/3 has updated Policy and Procedure regarding Medications and Medication Administration to include directions for storage of medications to include the following: All medications must be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight degrees centigrade.	10/3/2024

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S 630	Continued From page 11 ice. *On the shelf beneath the freezer compartment were four small boxes of insulin pens. -The paper-based boxes were either wet or had pieces of ice stuck to them. *A prescription label on another insulin box was smeared from having been wet and was illegible. *The thermometer inside the refrigerator read 44 degrees Fahrenheit. -That was an acceptable temperature range for medication storage. Observation and interview on 9/17/24 at 9:30 a.m. with manager/unlicensed medication aide (UMA) C in the kitchen revealed: *There was a medication refrigerator temperature log that was completed daily by staff. -All documented refrigerator temperatures for September 2024 were within an acceptable range. *Manager/UMA C concluded the medication refrigerator was not securely shut at some point to have caused the ice build-up beneath the freezer compartment and the wet insulin boxes. Review of the provider's undated Policy and Procedure regarding Medications and Medication Administration revealed: *Medication Control: -"2. All prescribed medications must be steroid [stored] in proper storage. Non-refrigerated medication is stored in a locked medication cabinet, inaccessible to residents or visitors." -There was no guidance related to the storage of refrigerated medication. *"8. Each original prescription container must be labeled with the resident name, drug name, strength, prescribers name, directions for use, prescription dispense date and expiration date."	S 630	S630 continued.... Facility administrator during monthly audit checks as noted above will verify expiration dates of all stored medications and any expired medication to be destroyed per facility policy/procedures. Record of this monthly audit to be kept in audit binder as noted above.	10/3/2024

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S 633	Continued From page 12	S 633		
S 633	44:70:07:04 Storage And Labeling Of Medications A container with a medication that will not be used within thirty days of issue or with contents that expire in less than thirty days of issue must bear an expiration date. If a single-dose system is used, the medication name and strength, expiration date, and a control number must be on the unit dose packet. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to ensure one of one vial of expired tuberculin (TB) stored in the medication refrigerator was removed and properly disposed of. Findings include: 1. Observation on 9/16/24 at 8:45 a.m. of the medication refrigerator revealed it contianed a TB vial labeled with the following instructions: "Discard after 4/20/24." Interview on 9/17/24 at 8:51 a.m. with registered nurse (RN) B regarding the above TB vial revealed she: *Last used serum from that vial for an employee TB test about "a week and a half ago." -Should have date-marked the vial when it was first opened and then disposed of it 30 days after that opened date. Review of the provider's undated Policy and Procedure Regarding Medications and	S 633	S633 Facility administrator during monthly audit checks as noted above will verify expiration dates of all stored medications and any expired medication to be destroyed per facility policy/procedures. Record of this monthly audit to be kept in audit binder as noted above, copy of audit to be kept in facility audit binder. TB vial was destroyed per facility policy/procedure prior to 10/3/2024.	10/3/2024

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S 633	Continued From page 13 Medication Administration revealed: *Medication destruction: "2. If the medication is no longer ordered, expired or resident has passed away the medication is to be counted and destroyed in set coffee grounds by facility RN with witness and documented on medication destruction log."	S 633	S670 Facility administrator as part of new hire orientation will schedule training (coordinated with facility contracted RN and new hire) to complete UMA training upon hire, date of training indicated on orientation checklist. In addition record of this training to be maintained in staff binder indicating date of initial training as well as annual review/ training. This is included in new hire orientation checklist also maintaining in staff training binder. For staff UMA D training was completed during new hire and subsequently documented during annual review/assessment July 2024 and for UMA E training was completed prior to 10/3/2024 by facility contracted RN. Copy of training maintained in staff training binder. Annual training (typically June) moved to July 5th, 2024 due to holiday included skills review and diabetic information presented by facility contracted RN to all UMA staff. Administrator updated staff training binder to reflect documented completion of this training as it was reviewed during annual review in July 2024. The UMA annual checklist as provided by SD Board of Nursing (2019) does not specifically reflect training of UDA skills so all UMA staff will also complete training prior to Oct 30, 2024 provided by facility contracted RN including post test to be maintained in staff training binder. Facility administrator to ensure completion of UMA and UDA training for all staff by Facility Contracted RN annually as scheduled for June 2025 and upon hire as part of new hire checklist. For UMA annual checklist will be used and UDA copy of post testwill be maintained in staff training binder. Administrator will conduct audit of staff training binder annually during annual review copy maintained in Audit Binder.	10/30/2024
S 670	44:70:07:07 Medication Administration A registered nurse shall provide medication administration training pursuant to § 20:48:04.01 to any unlicensed assistive personnel employed by the facility who will be administering medications. Unlicensed assistive personnel shall receive initial and ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the facility. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on personnel file review, interview, and job agreement review, the provider failed to ensure two of two sampled unlicensed medication aides (UMAs) (D and E) received initial training for medication administration. Findings include: 1. Review of personnel files revealed: *UMA D's hire date was 1/14/24. *UMA E's hire date was 8/1/24. -There was no documentation to support UMAs D and E had received initial medication administration training. Interview on 9/17/24 at 12:50 p.m. with	S 670		

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S 670	Continued From page 14 administrator A regarding UMA training requirements revealed she was aware of the annual medication administration training requirement but not the initial medication administration training requirement. Review of the 5/15/24 agreement document between the provider and registered nurse (RN) B revealed: "8. Provide monthly, annually and as needed training and inservice programs to staff to ensure that UMA certification remains current and that staff remain up to date with all necessary criteria and expectations of supervisor [RN B] or covering RN."	S 670		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not	S 685		

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S 685	Continued From page 15 met as evidenced by: Surveyor: 40788 Based on observation, record review, interview, and policy review, the provider failed to ensure residents were assessed to self-administer medications safely for: *One of one sampled resident (1) who self-administered insulin. *Two of two sampled residents (5 and 6) who self-administered an inhaler. *One of one sampled resident (6) who self-administered a nasal spray. Findings include: 1. Observation and interview on 9/16/24 at 11:45 a.m. with unlicensed medication aide (UMA) C as she prepared resident 1's insulin pen for self-administration revealed: *She primed the pen then turned the dial of the pen to "6" units. *She handed the pen to the resident after the resident wiped her abdomen with an alcohol pad. *Resident 1 inserted the insulin pen needle into her abdomen, pushed the dose button, and administered the insulin. *UMA C thought registered nurse (RN) B or the resident's medical provider was responsible for completing a medication self-administration assessment that would have verified the resident was able to safely and independently administer her insulin. 2. Observation on 9/17/24 at 8:00 a.m. of UMA C while in resident 5's room revealed: *UMA C handed the resident her Ellipta (medication to improve breathing) inhaler. -Resident 5 inhaled one puff as ordered. -Swished water in her mouth from a Dixie cup handed to her by UMA C, then spit the water back into that same cup.	S 685	S685 Facility Administrator to coordinate upon admission completion of the self-administration form by Contracted Facility RN assessing resident ability to self-administer medications consistent with updated form, form update includes: resident assessment of ability to participate in portions of medication self-administration under supervision of UMA as determined by facility contracted RN, this includes dose, route, details of residents participation, e.g. injecting pen, after staff prime, dial review with resident. Facility RN to complete assessments for all residents by Oct 30, 2024 and Facility administrator to audit each chart to ensure completion of updated self-assessment form by Oct 30 2024. Both self-assessment form and policy updated by facility administrator by Oct 17, 2024 portions of supervised self-administration. and updated policy self-administration policy to reflect quarterly reassessment for residents ability to safety self-administer/changes in ability to do so as determined by Facility Contracted RN. In addition facility administrator and facility contracted RN complete are responsible for ensuring care plan for each resident is completed upon admission, 30 day reassessment care plan is reviewed and updated as well as annually to include review with facility contracted RN. Also after any significant change in level of care. This care plan includes details regarding residents ability to safety administer medications as well as ongoing review of ability for resident to continue to do so. Continued....	10/30/204

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S 685	Continued From page 16 3. Observation and interview on 9/17/24 at 8:05 a.m. of UMA C while in resident 6's room revealed: *UMA C handed the resident her Calcitonin (medication for bone loss) nasal spray. -Resident 6 closed her left nostril while she inhaled one squirt of nasal spray into her right nostril as ordered. *UMA C then handed the resident her Symbicort(medication to improve breathing) inhaler. -Resident 6 inhaled two puffs as ordered. -She swished then swallowed water from the Dixie cup handed to her UMA C. *UMA C stated the resident was supposed to have spit the water in her mouth back into the Dixie cup. Review of residents 1, 5, and 6's care plans revealed the following intervention: "If I am self-administering medications, the nurse will review this every 3 months and with any significant change to ensure I am safe to do this." Telephone interview on 9/17/24 at 11:50 a.m. with RN B revealed she thought a resident's medical provider was completing residents' medication self-administration assessments. Interview on 9/17/24 at 1:10 p.m. with administrator A regarding medication self-administration assessments revealed: *A Resident Self-Administration of Medications form was expected to be completed for residents who self-administered medications. The form included the following yes/no questions: --Resident able to self-administer medication? -Can resident read and comprehend the label? -Does resident understand the purpose of the	S 685	S685 continued.... For residents who require medication administration. Each shift UMAs will continue to observe and report any changes in resident's abilities to take medications as prescribed under supervision and changes in this are reported immediately to Facility Contracted RN, in addition RN during weekly nursing follow up visits) for each resident will monitor for changes that may affect a resident's ability to take medications as prescribed under supervision of UMAs, this includes changes in residents ability to participate in self-administration under supervision of UMA. RN to update facility administrator of any change in residents status (health) that may indicate need for higher level of care is required. For residents 1, 5, and 6 updated self-medication administration forms to be completed prior to Oct 30, 2024 as well as all other residents to have forms updated by facility RN. Administrator to review each chart by Oct 31 to ensure compliance copy maintained in audit binder and annually thereafter.	10/30/2024

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S 685	Continued From page 17 medication prescription? -Can resident open the container? -Does resident take the medication as prescribed? *The form had not included a standardized checklist that was regularly administered and used to assess the resident's ability to safely and correctly take each medication they were self-administering. Copies of residents 1, 5, and 6's Resident Self-Administration of Medications forms were requested of administrator A on 9/17/24 at 1:15 p.m. and at 1:55 p.m. The following was provided: *A 7/11/24 "Assisted Living Waiver Review" form signed by RN B that indicated resident 1 "...has an assessed need for daily medication administration due to a cognitive impairment." *An unsigned Resident Self-Administration of Medications form for resident 5 that indicated the resident: -Was unable to self-administer medication or read and comprehend the prescription label. -"Somewhat" understood the purpose of the medication prescription. -"Requests assistance" to open the container. -Did not take the medication as prescribed due to a "Hx [history] of non-compliance, poor judgement." *There was no indication of what medication(s) this form had applied to. *An 11/1/23 "Assisted Living Medication Management" form signed by an advanced practice registered nurse which stated "They [resident 6] cannot safely self-administer their medication on their own due to mental illness with cognitive decline". Review of the provider's undated Policy and Procedure Regarding Medications and	S 685		

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S 685	Continued From page 18 Medication Administration revealed: *Self-Administration of Medications: -"If self-administration of medication is required, upon admission to the facility, the facility nurse will observe incoming resident(s) to determine that resident is able to self-administer medications. Statements will be obtained from the nurse and attending physician stating that resident self-administration of medications is safe."	S 685		
S 782	44:70:09:02(7) Facility To Inform Resident Of Rights The information must contain: (7) The resident's right to formulate a durable power of attorney for health care as provided in SDCL chapter 59-7 and a living will declaration as provided in SDCL chapter 34-12D; and This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on record review, interview, and policy review, the provider failed to ensure one of four sampled resident's (1) resuscitation code status preference was accurately identified. Findings include: 1. Review of resident 1's care record revealed: *On the cover of her care record was type-written, resident-specific information that included her allergies and code status. -Resident 1's code status was identified as a "full code" (the initiation of life saving measures in the event of a cardiac or respiratory arrest).	S 782	S782 Facility administrator during admission reviews code status preference for each resident and/or POA/ guardian and lists this information on chart, MAR, emergency contact sheet for each resident. Previous code status information is also obtained during prescreening process, contained in referral information or requested by facility administrator to ensure preferences known/followed. Code status is reviewed with resident's physician within 30 days of admission (per facility admission policy resident is scheduled to be seen by PCP within 30 days). If there is to be change in code status this is discussed with resident/ POA/Guardian before change is made to code status. As was the case with resident 1 who admitted with full code status but following review with physician resident requested to change status and family concurred with residents decision). Code status will continue to be reviewed/obtained by Administrator as part of admission application including two forms maintained in legal section of resident's chart. Changes to code status are to be updated by Facility Administrator including updating binder, MAR and emergency contact information sheet. Facility administrator will audit all resident's charts no later than Oct 15, 2024 and annually ongoing to ensure accurate code status is identified as noted above.Copy of chart audit maintained in facility audit binder.	10/15/2024

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S 782	Continued From page 19 *A Code Status form inside of resident 1's care record signed on 6/27/24 by her power-of-attorney (POA) indicated the resident's code status preference was "Do Not Resuscitate" [DNR] (no initiation of life saving measures in the event of a cardiac or respiratory arrest). Interview on 9/17/24 at 8:30 a.m. with manager/unlicensed medication aide (UMA) C regarding residents' code statuses revealed they were found for each resident on the inside of the Medication Administration Record (MAR) binders, on the cover of the resident's care record, and on the inside of the Resident Care Notes binder. Review of the MAR binder with manager/UMA C at that same time revealed resident 1's code status was identified as a full code. Observation on 9/17/24 at 8:40 a.m. of the Resident Care Notes binder revealed resident 1's code status was identified as a full code. Interview on 9/17/24 at 12:40 p.m. and review of the signed Code Status form referred to above with administrator A revealed: *Resident 1's code status had been a DNR since her admission on 6/27/24. -The cover of the resident's care record, the inside of her MAR binder, and the inside of the Resident Care Notes binder had inaccurately identified her code status preference as a full code. Review of the provider's policy and procedure binder last reviewed and revised by administrator A on 2/2/24 and interview on 9/17/24 at 12:40 p.m. with administrator A revealed there was: *No policy related to advance directives. -There was only a copy of the "Code Status" form	S 782		

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S 782	Continued From page 20 used to identify a resident's code status preference.	S 782		