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
	46723	A. BUILDING: _____ B. WING _____	C 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD GREENLEAF FLANDREAU LLC	800 S WIND ST FLANDREAU, SD 57028

(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 9/22/26 through 9/24/26. Edgewood Greenleaf Flandreau LLC was found not in compliance with the following requirements: S145, S172, S215, S305, S331, S337, and S835. 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 9/22/26 through 9/24/26. Areas surveyed included quality of life, potential verbal abuse, pharmaceutical services, potential resident neglect, physical environment, and admission, transfer, and discharge rights. Edgewood Greenleaf Flandreau LLC was found in compliance.	S 000		
S 145	44:70:02:12 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in two randomly observed resident bathrooms (106 and 113). Findings include:	S 145	On 10/07/2026, an exhaust fan was identified on the roof serving the bathrooms in units 100-115, the west public restroom, and the chemical room. The fan motor had failed, and the associated wiring was found to be in poor condition. On 10/08/2026, the maintenance technician removed a non-functioning timer that was no longer needed. On 10/12/2026, the technician replaced the exhaust fan motor and repaired the wiring. The exhaust ventilation system was subsequently tested and verified to be operating properly.	10/12/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alison Johnson	Executive Director	10/20/2026

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S 145	Continued From page 1 1. Observation on 9/23/26 at 11:54 a.m. revealed the exhaust ventilation for the bathroom in resident room 106 was not functioning. Testing of the exhaust inlet with tissue paper at the time of the observation confirmed that finding. Interview with maintenance tech C at that same time revealed he was unaware of the status of the required exhaust in that location. 2. Observation on 9/23/26 at 1:01 p.m. revealed the exhaust ventilation for the bathroom in resident room 113 was not functioning. Testing of the exhaust inlet with tissue paper at the time of the observation confirmed that finding. Interview with maintenance tech C at that same time revealed he was unaware of the status of the required exhaust in that location. He went on to add he believed that condition would be found in all of the residents' bathrooms not located in the west addition.	S 145		
S 172	44:70:02:17(6-7) Occupant Protection The facility shall: (6) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in a facility; (7) Ensure that any light fixture located over a resident bed, over a bathing fixture or treatment area, in a clean supply storage area, or in any medication set-up area be equipped with a lens cover or a shatterproof bulb; This Administrative Rule of South Dakota is not	S 172	Resident rooms 100-115 had their existing heat lamp bulbs replaced with shatter-resistant heat lamp bulbs.	10/12/2026

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S 172	Continued From page 2 met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure light fixtures located over bathing fixtures were equipped with a shatter proof bulb or a bulb cover in 2 randomly observed resident bathrooms (106 and 113). Findings include: 1. Observation on 9/23/26 at 11:54 a.m. revealed a heat lamp bulb above the shower in room 106. Testing of that bulb revealed it was not shatterproof and did not have a cover. Interview with maintenance tech C at that same time revealed he was unaware of the requirements to have shatterproof bulbs or a cover for heat lamps in resident bathrooms. 2. Observation on 9/23/26 at 1:01 p.m. revealed a heat lamp bulb above the shower in room 113. Testing of that bulb revealed it was not shatterproof and did not have a cover. Interview with maintenance tech C at that same time revealed he was unaware of the requirements to have shatterproof bulbs or a cover for heat lamps in resident bathrooms	S 172		
S 215	44:70:03:03 Fire Extinguisher Equipment Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square	S 215		

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S 215	Continued From page 3 meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to inspect all fire extinguishers monthly as required for three randomly observed locations (maintenance room, corridor outside of the kitchen, and at the east smoke barrier doors). Findings include: 1. Observation on 9/23/26 at 11:20 a.m. revealed the fire extinguisher in the maintenance room across from the kitchen did not have monthly inspections performed for the months of January, March, May, July, and August of 2026. Interview with maintenance tech C at the same time as the observation revealed he had only been employed there for four months and stated; while he couldn't control any of the missed months of the early part of the year, he must have missed that extinguisher. 2. Observation on 9/23/26 at 11:32 p.m. revealed the fire extinguisher in the corridor just outside the kitchen did not have a monthly inspection performed for the month of March in 2026. Interview with maintenance tech C at the same time as the observation revealed he had only been employed there for four months and stated; he couldn't control any of the missed months of	S 215	Docementation created to assist Maintenance technician to identify all locations and quantity of fire extinguishers. ED will also audit that Maintenance technician completes monthly inspections for four months with an end date of January 2027	10/12/2026

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S 215	Continued From page 4 the early part of the year as he was not working there at that time. 3. Observation on 9/23/26 at 11:32 p.m. revealed the fire extinguisher in the corridor just to the west of the east smoke barrier doors did not have a monthly inspections performed for the months of April and May in 2026. Interview with maintenance tech C at the same time as the observation revealed he had only been employed there for the previous four months and stated; he couldn't control any of the missed months of the early part of the year as he was not working there at that time.	S 215		
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to ensure one of six sampled employees (B) were evaluated by a licensed health professional and determined to be free from communicable diseases within fourteen days of being hired. Findings include: 1. Review of the personnel file for employee B revealed she was hired on 6/2/25 as the clinical	S 305	The community will maintain a personal health program to protect residents before starting assigned duties or within 14 days of hire. Each employee must be evaluated by a licensed health professional for any reportable communicable disease that could put others at risk. BOD will audit that health history screening forms are completed monthly for three months and there after. Audit findings will be reviewed at monthly QAPI meetings held the 3rd Wednesday of every month.	10/09/2026

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S 305	Continued From page 5 services director. Her evaluation by a licensed health professional was completed on 3/17/26. That was nine months after she was hired. 3. Interview on 9/23/26 at 12:03 p.m. with executive director A revealed clinical services director B was not evaluated by a licensed health professional within fourteen days of her employment and should have been. 6. Review of the provider's April 2026 Personnel Health Program policy revealed "The facility will maintain a personnel health program to protect residents. Before starting assigned duties, or within 14 days of hire, each employee must be evaluated by a licensed health professional for any reportable communicable disease that could put others at risk."	S 305		
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	S 331	CSD administered 1st step TB mantoux to employee E on 10/06/26. First TB test read by CSD on 10/08/2026 2nd TB test will be administered on 10/13/26 and read by CSD on 10/15/26. CSD implemented a TB New Hire Checklist that will be provided to new employees on first day of employment that provides employees dates scheduled for TB test given and dates employee is scheduled for reading TB. CSD will audit that TB test are completed within 21 days of hire or obtain documented two step tuberculin skin test/TB blood assay test completed within a 12 month period prior to date of employment monthly for 4 months. Audit finding will be reviewed at communities monthly QAPI meeting held on the 3rd Wednesday of every month.	10/15/2026

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S 331	Continued From page 6 or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been 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 personnel file review, interview, and policy review, the provider failed to ensure one of six sampled employee (E) received a tuberculin (TB) two-step skin test or blood assay test within twenty-one days of employment, or provided evidence that the employee received a negative TB test in the twelve months before employment. Findings include: 1. Review of the personnel file for employee E revealed she was hired on 4/23/26 as a personal care attendant (PCA). There was no documentation that she was tested for TB within twenty-one days of her employment. 2. Interview on 9/23/26 at 12:03 p.m. with executive director A regarding PCA E revealed her TB testing was not in her personnel file and it	S 331		

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S 331	Continued From page 7 should have been. They were waiting for documentation from her former employer. 3. Interview on 9/24/26 at 12:17 p.m. with clinical services director B regarding PCA E's TB testing revealed they had received documentation from her former employee and she had received a two-step TB test completed on 11/13/23 and on 11/16/23. They should have completed a two-step TB skin test or blood assay test within twenty-one days of her hire date. 4. Review of the provider's September 2026 TB Screening policy revealed "Each healthcare employee or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin test within 21 days of employment or admission. This test will be administered and ready by a licensed nurse. Any two documented tuberculin skin tests completed within 12 months prior to the date of admission or employment are considered two-step."	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: Based on observation, interview, manufacturer's recommendations, and policy review, the provider failed to ensure professional standards of practice were followed regarding insulin pen	S 337	CSD re-educated all current CMA's that residents are to prime their insulin pens to two units prior to administering prescribed insulin dose on 10/06/2026. CSD will complete new medication self administration assessments on residents that self inject medication on 10/16/2026 to ensure resident compentency. Self administration assessments will be completed every 90 days per regulation or with change in resident condition.	10/16/2026

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S 337	Continued From page 8 preparation and administration for one of one sampled resident (7) by one of one observed certified medication aide (CMA) (D) was completed. Findings include: 1. Review of resident 7's undated medication self-administration assessment revealed he was fully capable of self-administering subcutaneous injections. Medications listed included "Lantus Flexpen and Novolog Flexpen" (an insulin used to control blood sugar levels in people with diabetes). 2. Observation and interview on 9/23/26 at 7:20 a.m. with CMA D revealed she removed two Flexpens from a clear plastic bag. She went to resident 7's room and handed the Lantus Flexpen to resident 7 and instructed him to dial the Flexpen to 18 units. He then self-administered the insulin. CMA D then took the Novolog Flexpen and handed it to resident 7 and instructed him to dial the Flexpen to 4 units. He then self-administered the insulin. CMA D had not instructed resident 7 to prime either Flexpen's according to manufacturer's recommendations. Resident 7 had not primed either Flexpen before he administered both insulins. Interview following the above observation with CMA D revealed she nor resident 7 had primed the Novolog Flexpen or the Lantus Flexpen by wasting 2 units of insulin prior to dialing up the scheduled doses. She stated that she had not been trained on priming an insulin Flexpen prior to administration. 3. Interview on 9/23/26 at 10:55 a.m. with clinical services director (CSD) B regarding the above	S 337	Continued from page 8 CSD will audit employees utilizing the insulin pen preparation audit tool monthly for 3 months than there after. Audit findings will be reviewed in communities monthly QAPI meeting held on the 3rd Wednesday of every month.	

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S 337	Continued From page 9 observation revealed that CMAs are not allowed to dial the insulin Flexpens. She expected the CMA to hand the resident the insulin Flexpen and then the resident was to dial the insulin Flexpens to the scheduled doses. They would prime the insulin Flexpens before administering the first dose, but not following further doses. She was unaware the insulin Flexpens were to be primed before each dose. Continued interview on 9/23/26 at 11:30 a.m. with CSD B confirmed the manufacturer's directions regarding the Lantus Flexpen and the Novolog Flexpen were not in the plastic bag containing the Flexpens. 4, Review of the provider's September 2026 Insulin Pen policy revealed "Insulin-Pen Tasks. Priming the insulin pen, dialing the prescribed dose, and injecting the insulin are considered parts of insulin administration and may be completed by a licensed nurse or a medication aide who has successfully completed the approved Diabetes Aide course." "Self-Administration Assessment. A resident who self-administers insulin must be reassessed at least every 90 days and whenever there is a change in condition that may affect the resident's ability to safely self-administer insulin." 5. Review of the manufacturer's recommendations received on 9/23/26 at 4:00 p.m. from CSD B regarding Lantus Flexpen and Novolog Flexpen stated that "before each injection turn the dose selector to select 2 units by turning the dose selector until the dose pointer is at the 2 mark. Then press the injection button all the way in. When the insulin comes out of the needle tip, your pen is working correctly."	S 337		

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S 835	Continued From page 10	S 835		
S 835	44:70:09:09(1) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: (1) A safe, clean, comfortable, and homelike environment; This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and suicide procedure review, the provider failed to identify one of one sampled resident (6) with suicidal tendencies, ensure resident safety was maintained, updated the service plan, and follow the facilities suicide procedure policy. Findings include: 1. Review of resident 6's care record revealed she admitted to the facility on 2/26/26. Her diagnoses included bipolar disorder [a condition that causes periods of severe changes in mood, activity, levels, energy, and the ability to carry out everyday tasks], anxiety [mental health condition that cause excessive, persistent fear or worry that interferes with daily life], non-compliance with other medical treatment, post traumatic stress disorder (PTSD) [condition that can develop after experiencing or witness a terrifying, dangerous, or life threatening event], irritable bowel syndrome [long-term digestive condition that affects the large intestine], and hypertension [high blood pressure]. Her 2/21/26 Saint Louis University Status (SLUMS) examination for detecting cognition score was 21/30 indicating	S 835	On 09/24/2026 CSD called RND and informed current suicide procedure being to vague. CSD was informed by RND that corporate office was holding a policy meeting on 09/24/2026. Policy was updated on 09/24/2026. Clinical services manual was updated on 09/24/2026. On 10/07/2026 CSD updated resident 6 evalution and service plan to reflect history of suicidal comments and staff interventions. CSD educated at monthly all staff meeting about updated suicidal ideation procedure.	10/07/2026

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S 835	Continued From page 11 mild cognition impairment. Her 7/17/26 individual service plan had not included suicidal tendencies and interventions. She received psychoactive medications of clonazepam, quetiapine, and Trazadone. Review of resident 6's individual care report notes revealed note on 8/14/26 at 11:26 p.m. that stated.: "Feeling suicidal - Talked to staff about it and felt better." There was a note on 8/15/26 at 6:51 a.m. that stated: "Resident was not feeling good. She was talking about having suicidal thoughts to the CMA [certified medication aide] before me when I got here, she looked sad in the morning too." On 8/15/26 at 9:58 a.m. there was a note that stated: "NC (night) shift reported that resident was having suicidal thought and anxiety last night and was up late. They also reported RN (registered nurse) and ED (executive director) are aware. Writer checked on the resident around 9 AM to make sure she is okay. Writer immediately notifies RN/SD (clinical services director) and ED about the resident wants and was instructed to chart the behavior." On 8/17/26 at 11:25 a.m. a note stated: "1 episode of suicidal comments, no intention or plan. When staff went to check on resident to ensure safety resident became agitated because she got woken up. 1 episode of agitation R/T (related to) menu, encouraging another resident into complaining about the menu." On 7/27/26 she was seen by a new primary care physician with new orders to "set-up with psych [psychiatry] for help with management as well." 2. Interview on 9/23/26 at 2:45 p.m. with ED A and clinical services director (CSD) B regarding resident 6's suicidal ideation revealed there were 4 suicidal ideation entries in her care record.	S 835		

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EDGEWOOD GREENLEAF FLANDREAU LLC	800 S WIND ST FLANDREAU, SD 57028

(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 835	Continued From page 12 They expected the staff to have documented if she had a plan or no plan to harm herself. The physician should have been notified. There was no follow-up documentation if all the staff had been made aware of her suicidal ideation. There was no documentation if she had been monitored frequently during the suicidal ideation statements. Her service plan had not been updated to reflect suicidal ideation's or interventions. They felt the Suicide procedure was vague and should have included more information on how to continue with care for an individual who was at risk for self-harm. 3. Interview on 9/24/26 at 12:30 p.m. CSD B and ED A planned to visit with her later and ask if she wanted to reschedule the psych appointment and would let her primary care physician know. 4. Review of the provider's September 2026 Suicidal Ideation procedure revealed "Document - if the resident does or does not have a plan for self-harm. Be sure to include the resident's "plan" if there is one. It's ok to asks staff to ask the resident if they are thinking of harming themselves and if they have a specific plan. Document resident or staff commentary on the plan in quotation marks. Instruct staff to notify EMS [emergency services] if necessary. Residents with active thoughts of self-harm that do or do not include a "plan" should be evaluated."	S 835		

Insulin Pen Preparation Audit Tool

Purpose: To establish and maintain policies, procedures, and practices that follow accepted standards of professional practice governing resident care and related medical services. This audit assesses compliance with professional standards for insulin pen preparation, administration, storage, and documentation to ensure resident safety and quality of care.

Facility: _____
Unit/Department: _____
Audit Date: _____
Auditor: _____

Insulin Pen Preparation

Audit Criteria	Yes	No	N/A	Comments
Staff perform hand hygiene before medication preparation.	☐	☐	☐	
Medication order is reviewed before preparation.	☐	☐	☐	
Blood glucose results are verified prior to preparing insulin, when ordered.	☐	☐	☐	
Staff verify the correct resident, insulin type, dose, and administration time.	☐	☐	☐	
Staff inspect insulin for discoloration, particles, or damage before use.	☐	☐	☐	
A new needle is attached immediately prior to each injection.	☐	☐	☐	
Pen is primed according to manufacturer instructions before dosing.	☐	☐	☐	
Correct dose is dialed by resident and verified prior to administration.	☐	☐	☐	

Signatures

Employee: _____ Date: _____

Evaluator: _____ Date: _____

Comments:

_____
_____
_____
_____