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
	11040	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA TOWNE SQUARE	1425 15TH AVENUE SE ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/4/25 through 11/6/25. Bethesda Towne Square was found not in compliance with the following requirements: S030, S105, S106, S295, S352, S642, S652, S685, and S800. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/4/25 through 11/6/25. The area surveyed included a resident that fell and fractured her hip during a power outage at the facility. Bethesda Towne Square was found in compliance.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report any of the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and or other critical equipment necessary for operation of the facility for more than twenty-four hours;. (7) Any unsafe drinking water samples, or samples from pools or spas.	S 030	Facility's *Controlled Substance Administration and Accountability Policy* was reviewed and revised to include a process for *Discrepancy Resolution* and reporting. Education will be provided by Director of Assisted Living by 12/21/25 for all licensed nursing staff and medication aides on the updated Discrepancy Resolution and reporting process per policy. Director of Assisted Living or designee will audit any incidents for compliance upon occurrence and will report findings to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	12/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Eisenbeisz
TITLE: CEO/Administrator
(X6) DATE: 11-26-25

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S 030	Continued From page 1 The facility shall conduct an internal investigation of the event and report the results to the department no later than five working days after the event. The department may request additional information from the facility and investigate any reported event. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview, and policy review the provider failed to ensure one of one allegation of potential medication diversion was reported to the South Dakota Department of Health (SD DOH). Findings include: 1. Observation on 11/5/25 at 11:05 a.m. of the medication carts revealed: *There were two medication carts, one cart for the first floor (100s rooms) and another for the second floor (200s rooms). *The second-floor medication cart had a locked drawer within the cart labeled "Narc" which contained the controlled medications (medications with risk for abuse, addiction, and potential theft). *Within the locked drawer of controlled medications was a three-ring binder which contained the Narcotic Shift Counting Record and Controlled Drug Receipt/Record/Disposition form for each resident's controlled medications. *On resident 3's Controlled Drug Receipt/Record/Disposition form for "CLONAZEP	S 030		

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S 030	Continued From page 2 [clonazepam] ODT [orally disintegrating tablet] 0.25 MG [milligrams] [a prescription medication used for the treatment of anxiety] GIVE 1 TAB [tablet] (0.25MG) PO [by mouth] TWO TIMES DAILY" was a sticky note that stated, "Count is Off! 10/19/25 @ [at] 1830 [6:30 p.m.] [resident medical associate (RMA) J]". *On 10/13/25 60 tablets of clonazepam had been dispensed to resident 3 from the pharmacy. *On 10/15/25 licensed practical nurse (LPN) I signed that she had received the medication. *The Controlled Drug Receipt/Record/Disposition form stated, "Every dose must be accounted for and requires charting on the Medication Administration Record". *On 10/19/25 at 8:30 a.m. RMA J signed out one tablet of clonazepam for resident 3 and documented there were 53 tablets remaining. *On 10/19/25 at 8:30 p.m. RMA L signed out one tablet of clonazepam for resident 3 and documented there were 46 tablets remaining. 2. Review of the Narcotic Shift Counting Records for October 2025 revealed: *There was a column for the date and time of each controlled medication count to be documented. *There was a column for the "NURSE/RMA CHECKING IN" and the "NURSE/RMA CHECKING OUT" to sign when the controlled medication count was completed and accurate. *There were two signatures present for each count at 6:30 a.m. and 6:30 p.m. daily for the month of October. *On 10/18/25 at 6:30 p.m. LPN I and RMA K signed the controlled medication count was completed and was accurate. *On 10/19/25 at 6:30 a.m. RMA K and RMA J signed the controlled medication count was completed and accurate.	S 030		

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S 030	Continued From page 3 *On 10/19/25 at 6:30 p.m. RMA J and RMA L signed the controlled medication count was completed and accurate. *On the side of the Narcotic Shift Counting Record was a bracket between the 10/19/25 6:30 a.m. count and the 6:30 p.m. count which stated, "see note about off count". 3. Review of the provider's 10/19/25 Missing Narcotic investigation revealed: *On 10/19/25 at 6:30 p.m. LPN N, RMA L, and RMA J discovered six tablets of resident 3's clonazepam ODT 0.25 mg were missing during the controlled medication count. *LPN N, RMA L, and RMA J had searched for the missing clonazepam in both medication carts. *At 6:45 p.m. facility director B was notified of resident 3's missing clonazepam. -Facility director B instructed the staff to continue the controlled medication count and document the missing clonazepam on the Controlled Drug Receipt/Record/Disposition form, so the count was correct. -Facility director B was notified that the 10/19/25 morning controlled medication count was not completed because RMA K had signed the Narcotic Shift Counting Record and left prior to having completed the controlled medication count with RMA J and RMA J signed the Narcotic Shift Counting Record without having completed the controlled medication count with RMA K. -Facility director B spoke with RMA K, who was unable to explain where resident 3's missing clonazepam was. -Facility director B documented, "Since the narcotic count was not completed, the date/time of when the doses went missing is unknown. *On 10/20/25 facility director B documented: - That she and other staff members, "went through both med [medication] carts, including	S 030		

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S 030	Continued From page 4 removing all the drawers. We looked through the garbage that hadn't been taken to the dumpster yet and the shred bin, but the medications were not found. Staff believes the medication sleeve may have fallen out of the box when a dose was removed to be given and fell into the garbage can attached to the side of the med cart. Since the garbage has already been removed, this cannot be verified." -The pharmacy was notified of resident 3's missing clonazepam and replacements were ordered at the cost of the facility on 10/20/25. - "Due to resident not missing a scheduled dose and the facility covering the costs of the replacement medication, family and physician were not notified as investigation of the medication did not find concerns for theft." - Administrator A and RN M "have been notified of missing doses and are in agreement with follow-up and conclusion." *The Missing Medication/Narcotic Form included: - The staff who identified that there was a missing medication were LPN N and RMA J. -The clonazepam 0.25 mg tablets were discovered missing on 10/19/25 at 6:45 p.m. -The clonazepam was missing from the locked medication cart. -Resident 3 was not out of the building. -The medication carts, medication bins, nurses' station, and the garbage containers had been searched. -The medication was not found. -This form did not include who completed it or when. 4. Interview on 11/5/25 at 12:10 p.m. with LPN I regarding the controlled medication count revealed: *The controlled medications were counted at shift change by the RMA or nurse leaving the shift and	S 030		

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S 030	Continued From page 5 the RMA or nurse coming on shift. *The signature of the RMA or nurse would indicate the controlled medication count had been completed and the count of the controlled medications was accurate. *If a controlled medication count was found to be inaccurate facility director B was to be notified and she would instruct the RMA or nurse what to do next. *LPN I did not know if the primary care provider, resident representative, pharmacy, or the SD DOH were to be notified if there were controlled medications that were missing. *LPN I stated she had notified pharmacy the day after resident 3's controlled medications were identified as missing. 5. Observation and interview on 11/6/25 at 10:32 a.m. with LPN N revealed: *All controlled medications were kept in the locked drawer in the second-floor cart. *There were two set of keys that could open the medication carts and the controlled medication drawer. *The two RMAs or nurses on each shift would be in possession of the keys. *Each morning the RMA or nurse who was on the night shift would complete the controlled medication count with the oncoming RMA or nurse who would be administering medications with the second-floor medication cart on the day shift. *After the controlled medication count was completed and verified to be accurate the RMAs or RMA and nurse who completed the controlled medication count would sign the Narcotic Shift Counting Record. *On the morning of 10/19/25 LPN N was the nurse on duty. *When LPN N and RMA J arrived for their	S 030		

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S 030	Continued From page 6 morning shift on 10/19/25 the keys for the second-floor medication cart were lying on top of the cart. *RMA K was not able to be found to complete a controlled medication count. *On the morning of 10/19/25 a controlled medication count was not completed, even though both RMA K and RMA J had signed the Narcotic Shift Counting Record to indicate the controlled medication count had been completed. *LPN N stated that "99 percent of the time" the night shift tells the oncoming day shift staff that they had already counted the controlled medications. *On 10/19/25 at 6:30 p.m. RMA J and RMA L completed the controlled medication count and found resident 3 was missing six tablets of her clonazepam. *LPN N and RMA J searched for the missing tablets for over an hour in both medication carts, the garbage, the sharps containers, and anywhere else they thought the medications could have been misplaced. *After resident 3's clonazepam tablets were determined to be missing, facility director B was notified. *Facility director B instructed LPN N to make a note on the Narcotic Shift Counting Record and update the Controlled Drug Receipt/Record/Disposition form with the corrected controlled medication count. *LPN N removed the box of clonazepam from the medication cart and stated the clonazepam was not in a bubble packed card but rather in the manufacturer's box because it could not be bubble packed due to the oral disintegrating tablets that would disintegrate during the bubble packing process. *Within the manufacturer's box there were sheets of foil wrapped tablets. Each sheet had six tablets	S 030		

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S 030	Continued From page 7 in it. *The outside of the manufacturer's box indicated there were to be "60 (10 x 6) unit dose tablets" in the box when it was dispensed, and it was box one of one. *LPN N stated that she had interviewed all the staff who were certified to administer medications and only RMA O stated she opened the manufacturer's boxes and counted the controlled medications when she checked the medication in from pharmacy. *LPN N stated the pharmacy was notified on 10/20/25 due to it being after pharmacy hours when the missing clonazepam was identified. *She was unsure if resident 3's primary care provider, family, or the SD DOH had been notified of the missing clonazepam. *She stated law enforcement was not notified of the missing clonazepam. 6. Interview on 11/6/25 at 11:04 a.m. with RMA J revealed: *RMA J stated when he arrived at work on the morning of 10/19/25 the keys to the second-floor medication cart were unsupervised on top of the cart. *RMA K was not seen by RMA J, so he began administering medications to the residents. *When he was administering a controlled medication to a resident, he realized RMA K had signed the 10/19/25 6:30 a.m. Narcotic Shift Counting Record but he had not. RMA J signed the Narcotic Shift Counting Record to indicate the count had been completed and accurate even though the count had not been completed and was not verified to be accurate. *RMA J stated there were other times when the controlled medication count was not completed and the off going and on coming staff both signed that it had been completed, but this did not	S 030		

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S 030	Continued From page 8 happen often. *When he and RMA L identified there were six clonazepam tablets that were unable to be accounted for, he looked through the medication carts and the garbage containers. He stated he had removed the drawers from the carts to be sure the clonazepam had not fallen under or behind one of the drawers. *After he was not able to locate resident 3's six tablets of clonazepam, he notified LPN N. 7. Interview on 11/6/25 at 11:38 a.m. with registered nurse (RN) M revealed: *She stated the controlled medication count was to be completed between each change of shift by the on-coming nurse or RMA and the off-going nurse or RMA. *If the Narcotic Shift Counting Record was signed by two staff members, she would expect the controlled substance count had been completed and verified to be accurate. *When medications were found to be missing, she would expect the primary care provider, pharmacy, and the family to be notified of the missing medications. *The stated the medication cart keys should always be in constant possession of the RMA or nurse until they are passed on to the next shift. *She stated that leaving the medication cart keys unattended on top of the cart provided an opportunity for someone to open the medication cart and access the controlled substances within the locked controlled substance drawer. *She stated that leaving the medication cart keys unattended on top of the medication cart and staff not completing the medication count accurately, provided opportunities for drug diversion. 8. Interview on 11/6/25 at 12:47 p.m. with administrator A and facility director B revealed:	S 030		

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S 030	Continued From page 9 *Facility director B had been notified of resident 3's missing clonazepam on the evening of 10/19/25. *She verified that staff had searched for the missing clonazepam and then instructed them to document the missing medication on the Missing Medication/Narcotic Form, the Controlled Drug Receipts/Record/Disposition Form, and the Narcotic Shift Counting Record and then continue with the scheduled medication administrations. *Facility director B searched for resident 3's missing clonazepam and interviewed the involved staff on the morning of 10/20/25. *She verified clonazepam was a controlled substance and at high risk for abuse, addiction, and potential theft. *Facility director B stated she determined resident 3's clonazepam was not stolen because she could not verify that the correct number of tablets were received from the pharmacy. *Facility director B verified resident 3's clonazepam had been checked in from pharmacy by LPN I on 10/15/25 as having been 60 tablets, and the medication was administered seven times by five different staff members before the controlled medication count identified the missing clonazepam. *She stated she did not think it was theft because resident 3's clonazepam was not a new medication, the staff involved were established staff, and resident 3 was an established resident. *Facility director B agreed she was not able to prove the medication had not been stolen from resident 3. *Resident 3's family and primary care provider were not notified because the clonazepam was replaced at the cost of the facility and resident 3 had not missed any doses of her clonazepam. *Law enforcement was not notified. *Administrator A stated he did not expect that	S 030		

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S 030	Continued From page 10 resident 3's primary care provider, law enforcement, or family was notified of the missing medications. *Administrator A verified resident 3 had purchased the medications, therefore the clonazepam would have been the property of resident 3. *He verified family would be notified if a resident's property went missing and law enforcement would be notified with the input of family and depending on the value of the missing item. *Administrator A verified drug diversion was a crime, and they were not able to determine whether resident 3's clonazepam was stolen. *A facility reported incident (FRI) was not submitted to the SD DOH related to resident 3's missing clonazepam. *If it was determined a SD DOH FRI needed to be submitted facility director B or administrator A would submit the information or one of them would assist the nurse on duty to submit the information for the initial report. *Administrator A and facility director B stated they had not thought about submitting resident 3's missing clonazepam to the SD DOH because they had not experienced possible drug diversion before and had only submitted falls with injury. *They were not aware that misappropriation of resident property was within the provider's abuse and neglect policy and was reportable to the SD DOH. Review of the provider's April 2025 Delivery Service process revealed: *"Receiving Medications During the daily delivery process, each tote will be sealed with a zip tie. Upon arrival, totes will be unlocked, and the medication should be reviewed for accuracy & [and] compared to the accompanied packing slip."	S 030		

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S 030	Continued From page 11 *"All controlled substances will be enclosed in a sealed plastic bag, which facility staff will open and reconcile. Each controlled substance will be accompanied by a medication count sheet." Review of the provider's 1/11/24 Administration and Control of Narcotic policy revealed: *"Counting Narcotics a. Count narcotics at the change of each shift or change of staff b. The minimum requirement is to count every 12 hours. c. Two registered or licensed nurse/Medication Aide will count the narcotics using the Narcotic Counting Record." *"Missing Doses a. Rule out all sources of discrepancy b. Inform the Nurse and/or Director of Assisted Living Facility. c. Indicate the missing dose on the Narcotic Administration Record d. Complete a Missing Medication/Narcotic Form indicating a dose is missing". Review of the provider's 1/16/24 Abuse, Neglect, Misappropriation of Resident Property & Exploitation policy revealed: *"Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation." *"'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money." *"Response and Reporting of Abuse, Neglect and Exploitation - Anyone observing an incident of abuse or suspecting resident abuse must immediately report such an incident to the licensed nurse. This includes verbal, physical, sexual, or mental abuse, corporal punishment or	S 030		

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S 030	Continued From page 12 involuntary seclusion and misuse or damaging or theft of resident property." *"The licensed nurse will complete the Initial Facility Health Care reporting form within two hours if serious bodily injury. All others within 24 hours. This is done by going to the SD DOH web page. Click on the initial report form and fill out all the areas completely, including all details and then submit to the Department of Health Complaint Coordinator ... Give the printed form to the DAL [Director of Assisted Living]/Designee." *"The DAL /Administrator/Designee must complete the Investigation portion and complete the Final Facility Health Care reporting form within five working days of the incident in accordance with State law." *"In response to allegations of abuse, neglect, exploitation of mistreatment, including injuries of unknown source and misappropriation or [of] resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the advents [events] that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency and adult protected [protective] services where state law provides jurisdiction in long-term care facilities) in accordance with State law." *"Have evidence that all alleged violations are thoroughly investigated."	S 030		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in	S 105	On 11/5/2025 all unlabeled and non-dated food items were removed and discarded from freezer. Floor fan was cleaned on 11/5/2025.	12/21/25

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	11040	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA TOWNE SQUARE	1425 15TH AVENUE SE ABERDEEN, SD 57401

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S 105	Continued From page 13 accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to implement safe food storage and labeling practices in one of one sampled kitchen. Findings include: 1. Observation on 11/5/25 at 9:05 a.m. of the kitchen revealed: *The following items in the freezer did not identify a date they had been sealed. -An open package of frozen hashbrowns. -Two open packages of diced potatoes. -Two open packages of French fries. *The following items in the freezer were not labeled and did not have an open date -One package of what appeared to be chicken breast tenders. -Two packages of what appeared to be pre-cooked chicken patties. -One package of what appeared to be breaded chicken patties. *A floor fan, against the wall facing the steam table, was turned on and had dust and food spills on it. *A wall fan had been turned on and was facing the steam table. Dust and food spills were visible on the fan. *A stainless-steel cart by the dishwasher had a hammer, well-used scrub brush, bottle of Lime	S 105	On 11/6/2025 the following was done, wall fan that was facing clean side of dish washing area was removed, stainless steel chemical cart by dishwasher was cleaned and unnecessary items removed, plastic cart stored next to clean dishes was disposed of and replaced with new cart, cart storing clean plates was cleaned and booster under clean side of dishwashing area was scrapped and painted. On 11/7/2025 booster painting was completed, eliminating all signs of rust. Dinner plates moved to another storage location rather than underneath clean side of dishwashing area and plate cart was removed. Began 1-1 discussions with staff on proper labeling and dating food items. Follow up education on proper food storage and reporting anything requiring maintenance repairs will be provided to all culinary personnel by 12/9/25. Audits for proper food storage began on 11/24/25 and will be conducted daily for four weeks then weekly until QAPI determines sustained compliance. Visual inspection audits began on 11/24/25 and will be conducted weekly for four weeks, ensuring cleanliness and proper conditions of equipment then monthly thereafter. Audits will be conducted by Director of Culinary Services or designee. Director of Assisted Living will report monthly to QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 105	Continued From page 14 Away, bottle of hand-sanitizer, and a spray can of stainless-steel cleaner that had a sticky substance all over it. The stainless-steel cleaner had a disposable glove stuck to it. *A plastic cart that had standing water and water stains on the top of it was stored next to where the clean dishes came out of the dishwasher. *A cart that stored clean plates had food particles and dust on the base of it. *A booster heater for the dishwasher was rusted and flaking. It was located under where the clean dishes came out of the dishwasher, next to the cart that stored clean plates. 2. Interview on 11/5/25 at 9:15 a.m. with chef H and culinary associate G revealed: *The maintenance department was responsible for cleaning the fans in the kitchen. *The stainless-steel cart was to be cleaned each month by the kitchen staff. *Chef H indicated all food was to be sealed, labeled, and dated when opened. 3. Interview on 11/5/25 at 9:45 a.m. with dietary manager (DM) F revealed: *She indicated she had been "working on dating and labeling things in the refrigerator" and was not aware that dating and labeling food in the freezer was also an issue. *She was not aware of the following: -The floor fan facing the steam table and had dust and food spills on it. -The wall fan was blowing dust onto the clean dish area. -The stainless-steel cart that had a hammer, well-used scrub brush, bottle of Lime Away, bottle of hand-sanitizer, and a spray can of stainless-steel cleaner that had a sticky substance all over it with a disposable glove stuck to it.	S 105		

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S 105	Continued From page 15 -The plastic cart with standing water and water stains on it. -The cart that stored plates had food particles and dust on it. -The dishwasher booster heater was rusted. *She stated all areas of the kitchen should be cleaned by the dietary staff. 4. Review of the provider's 2021 Food Storage policy revealed: *"Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated." *"Frozen Foods:" -"All foods should be covered, labeled, and dated. All foods will be checked to assure [ensure] that foods will be consumed by their safe use by dates or discarded."	S 105		
S 106	44:70:02:06 Food Service A facility of seventeen beds or more shall have a mechanical dishwasher. The facility shall have the space, equipment, supplies and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure proper sanitation of dishes and dining room tables in one of one kitchen and dining area. Findings include:	S 106	On 11/5/2025 provided red sanitation buckets and sanitation test strips with expiration date of November 2026. Expired sanitation test strips disposed. Developed documentation sheets for sanitation test strips and hung on wall on a clipboard with test strips in basket next to clipboard. Began 1:1 education on use of sanitation bucket, sanitation test strips and documentation of strips to staff. Began monitoring at each meal for proper sanitation use, sanitation testing and documentation. 1:1 education on proper dishwashing temperatures and documentation and began monitoring dish machine temps prior to use of all meals to ensure getting to proper temperatures before use.	12/21/25

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S 106	Continued From page 16 1. Observation on 11/5/25 at 9:00 a.m. of the dining room revealed a green bucket with wash cloths in it. 2. Observation on 11/5/25 at 9:05 a.m. of the dishwashing area in the kitchen revealed: *There was a stainless-steel cart next to the dishwasher, and on this cart was a plastic container that had two boxes of sanitizing test strips stored in it. -One of the boxes was outdated on 1/23, and the other box was outdated on 6/23. *On the wall was a paper form labeled November 2025 Dish Machine Temperature Log. The form was not completed for the supper meal from 11/1/25 through 11/4/25. 3. Interview on 11/5/25 at 9:15 a.m. with chef H and culinary associate G revealed: *Chef H stated she was not shown how to use the test strips to test the sanitizing solution in the bucket that was used to wash the dining room tables. *Culinary associate G stated she had never tested the sanitizing solution and did not know how to do that. 4. Interview and record review on 11/5/25 at 9:48 a.m. with dietary manager (DM) F revealed: *The dishwasher was a high-temperature washer, and there were issues with the temperature of the dishwasher not being at the required temperature to sanitize the dishes "for several months". *She indicated that the maintenance department was monitoring the temperature and had informed her that the dishwasher was getting to the required temperature, and the gauge that monitored the temperature was not working. *She confirmed the maintenance department was not monitoring the dishwasher at each meal or	S 106	Plan if it does not reach appropriate temperatures, staff would transfer dishes to ADC (adjoining building) to wash dishes. Continued monitoring of dish machine temps each meal and documentation on dish machine temperature log. On 11/11/2025, updated and revised policies for cleaning dishes in dish machine, dish machine temperature log, and cleaning dishes manually. Developed policies for cleaning/sanitizing with red & green buckets and sanitizer test strips. Will provide 1:1 follow up education to all culinary personnel by 12/9/2025. Audits for visual use of sanitation buckets, sanitation testing and documentation, proper dishwashing temperatures and dishwashing temperature documentation will began on 11/24/25 and be conducted twice daily for two weeks, daily for two weeks, then weekly until QAPI determines sustained compliance. Audits will be conducted by Director of Culinary Services or designee. Director of Assisted Living will report monthly to QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 106	Continued From page 17 daily. *She indicated three types of temperature monitoring had been attempted in the past few months to determine the accurate temperature of the dishwasher, a "disk", thermal strips, and the gauge on the dishwasher, and all three had indicated the dishwashing was not getting to the required temperature for sanitation of 180 degrees fahrenheit (F). *Review of notification records to the maintenance department revealed she had notified them on 7/31/25, 10/6/25, and on 10/13/25 of the dishwasher not being at the required temperature to sanitize. *Review of the October 2025 Dish Machine Temperature Log with DM F revealed there were 93 opportunities for the dishwasher temperature to be at least 180 degrees F to sanitize the dishes. -For breakfast, there were 13 times the temperature of the machine for sanitizing was less than the required 180 degrees F, and 13 times the temperature was not taken. -For lunch, there were 12 times the temperature of the machine for sanitizing was less than the required 180 degrees F, and 15 times the temperature was not taken. -For supper, there were two times the temperature of the machine for sanitizing was less than the required 180 degrees F, and 28 times the temperature was not taken. *DM F was not aware that the dietary staff were not testing the sanitizing buckets, to ensure a proper sanitizing solution was used to clean dining room tables. *DM F was not aware that the test strips used for testing the sanitation of the buckets solution had expired in 2023. 5. Interview on 11/5/25 at 10:42 a.m. with	S 106		

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S 106	Continued From page 18 administrator A revealed he was aware there had been an issue with the dishwasher temperature "a couple of months ago" but thought it had been resolved. 6. Review of the provider's 2021 Cleaning Dishes/Dish Machine policy revealed: *"The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing." *"Prior to use, proper temperatures and/or chemical concentrations and machine function should be verified." *"Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. Thermal strips may be used as verification that the temperature is adequately hot, but cannot verify actual temperatures." 7. Review of the provider's 2021 Sanitation of Dishes/Dish Machine policy revealed a high temperature dishwasher: *Wash temperature was to be between 150 degrees Fahrenheit (F) and 165 degrees F. *Final rinse temperature or sanitization temperature for a was to be 180 degrees F. 8. Review of the provider's 2021 Dish Machine Temperature Log policy revealed: *"Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes." *"The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures." -"Staff will monitor dish machine temperatures throughout the dishwashing process." -"Staff will record dish machine temperatures for	S 106		

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S 106	Continued From page 19 the wash and rinse cycles at each meal. The director of food and nutrition services will spot check this log to assure [ensure] temperatures are appropriate and staff is correctly monitoring dish machine temperatures." -"Staff will be trained to report any problems with the dish machine to the director of food and nutrition services as they occur." -"The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes."	S 106		
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 two of two employees (E and D) had completed annual training the required topics. Findings include: 1. Review of licensed practical nurse (LPN) E's employee file revealed: *She was hired on 1/8/22. *There was no record of her completing infection control and prevention, accident prevention and safety, resident rights, and nutritional risks and hydration training in the past twelve months.	S 295	Facility created a policy for *Staff Continuing Education*. Education will be provided by Director of Assisted Living by 12/21/25 for all staff on the policy. All employees due will complete the required annual training by 12/21/25. Annual training process re-evaluated by Director of Assisted Living, Director of Employee Environment, and Administrator of facility to identify alternative education resources for attendance promotion. Director of Assisted Living or designee will audit staff education monthly for compliance and will report findings to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	12/21/25

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S 295	Continued From page 20 2. Review of activity department D's file revealed: *She was hired on 9/6/83. *There was no record of her completing fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety, resident rights, and nutritional risks and hydration training in the past twelve months. 3. Interview on 11/5/25 at 3:55 p.m. with facility director (FD) B regarding staff education/training revealed: *She confirmed employees D and E had not completed the above required annual training topics in the last twelve months. *She indicated staff had difficulty attending trainings, as many had other jobs. *She agreed that all employees should have completed annual training on the required topics. 4. Follow-up interview on 11/6/25 at 8:55 a.m. with FD B regarding employee annual training revealed that the director of employee engagement (DEE) C was responsible for ensuring annual training was completed. 5. Interview on 11/6/25 at 9:00 a.m. with DEE C and FD B revealed: *DEE C indicated she was responsible for ensuring employee annual training was completed. -Employees often had difficulty in attending annual training and were often unavailable at the scheduled time of training for various reasons. *DEE C confirmed AD D and LPN E had not completed the required annual trainings listed above.	S 295		

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S 352 S 352	Continued From page 21 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 a 30-day evaluation of care needs was completed for two of two sampled residents (1 and 2). Findings include: 1. Review of resident 1's care record revealed: *Her admission date was 6/9/25. *Her admission evaluation of care needs was completed on 6/9/25. *There was no documentation that her 30-day evaluation of care needs was completed. 2. Review of resident 2's care record revealed: *Her admission date was 10/25/24. *Her admission evaluation of care needs was completed on 10/25/24. *There was no documentation that her 30-day evaluation of care needs was completed. 3. Interview on 11/6/25 at 9:10 a.m. with facility director B regarding the resident's required 30-day evaluation of care needs revealed: *She was not aware of the requirement for a 30-day evaluation of care needs. *She stated the 30-day evaluation of care needs for residents 1 and 2 had not been completed.	S 352 S 352	Facility reviewed all admissions in the past 30 days and determined one resident will need to have a 30-day completed. This will be completed by 11/28/25. Facility's *Resident Assessment Policy* was reviewed and revised to include 30-day Evaluation of Care for all resident admission/re-admissions. Education will be provided by Director of Assisted Living by 12/21/25 for all licensed nursing staff on the policy. Director of Assisted Living or designee will audit resident admissions and re-admissions as they occur for completion of 30-Day Evaluation of Care and will report finding to monthly QAPI committee and quarterly to the QA&A committee with Medical Director until substantial compliance is met as determined by QAPI and QA&A committee.	12/21/25

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S 352	Continued From page 22 4. Review of the provider's undated Resident Handbook revealed "We acknowledge that we cannot guarantee to provide every single need or circumstance for our residents. However, staff conduct regular assessments of each resident to ensure the proper level of care is met. *There was no mention of a 30-day evaluation of care needs. 5. Review of the provider's 2/8/24 Resident Assessment Policy revealed there was no indication that a 30-day evaluation of care needs was to be completed for newly admitted residents.	S 352		
S 642	44:70:07:05 Control And Accountability of Medications The facility must receive written authorization from the resident's physician, physician assistant, or nurse practitioner before releasing any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview and policy review, the provider failed to follow their policies for controlled medications (medications with risk for abuse, addiction, and	S 642	Facility's *Controlled Substance Administration and Accountability Policy* was reviewed and revised to include a process for *Discrepancy Resolution* and reporting. Facility's *Keys to Medication Storage Policy* were reviewed and revised to include information regarding transferring of keys during shift change. Education was provided to all licensed nursing staff and medication aides on the proper procedure for Controlled Substance Shift Counts and improper documentation of controlled substance administration on 11/14/25 by Director of Assisted Living and Administrator. Education will be provided by Director of Assisted Living by 12/21/25 for all licensed nursing staff and medication aides on the updated policies. Director of Assisted Living or designee will audit Shift Narcotic Counts at minimum weekly for one quarter, then monthly	12/21/25

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S 642	Continued From page 23 potential theft) to ensure accountability for those medications related to their receipt, shift change medication counts, medication counts with administration, and the securement of keys that access the controlled medications. Findings include: 1. Observation on 11/5/25 at 11:05 a.m. of the medication carts revealed: *There were two medication carts, one cart for the first floor (100s rooms) and another for the second floor (200s rooms). *The second-floor medication cart had a locked drawer within the cart labeled "Narc" which contained the controlled medications. *Within the locked drawer of controlled medications was a three-ring binder which contained the Narcotic Shift Counting Record and Controlled Drug Receipt/Record/Disposition form for each resident's controlled medications. *On resident 3's Controlled Drug Receipt/Record/Disposition form for "CLONAZEP [clonazepam] ODT [orally disintegrating tablet] 0.25 MG [milligrams] [a prescription medication used for the treatment of anxiety] GIVE 1 TAB [tablet] (0.25MG) PO [by mouth] TWO TIMES DAILY" was a sticky note that stated, "Count is Off! 10/19/25 @ [at] 1830 [6:30 p.m.] [resident medical associate (RMA) J]". *On 10/13/25 60 tablets of clonazepam had been dispensed to resident 3 from the pharmacy. *On 10/15/25 licensed practical nurse (LPN) I signed that she had received the medication. *The Controlled Drug Receipt/Record/Disposition form stated, "Every dose must be accounted for and requires charting on the Medication Administration Record". *On 10/19/25 at 8:30 a.m. RMA J signed out one tablet of clonazepam for resident 3 and	S 642	thereafter, for compliance and will report findings to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	

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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 642	Continued From page 24 documented there were 53 tablets remaining. *On 10/19/25 at 8:30 p.m. RMA L signed out one tablet of clonazepam for resident 3 and documented there were 46 tablets remaining. 2. Review of the Narcotic Shift Counting Records for October 2025 revealed: *There was a column for the date and time of each controlled medication count to be documented. *There was a column for the "NURSE/RMA CHECKING IN" and the "NURSE/RMA CHECKING OUT" to sign when the controlled medication count was completed and accurate. *There were two signatures present for each count at 6:30 a.m. and 6:30 p.m. daily for the month of October. *On 10/18/25 at 6:30 p.m. LPN I and RMA K signed the controlled medication count was completed and was accurate. *On 10/19/25 at 6:30 a.m. RMA K and RMA J signed the controlled medication count was completed and accurate. *On 10/19/25 at 6:30 p.m. RMA J and RMA L signed the controlled medication count was completed and accurate. *On the side of the Narcotic Shift Counting Record was a bracket between the 10/19/25 6:30 a.m. count and the 6:30 p.m. count which stated, "see note about off count". 3. Review of the provider's 10/19/25 Missing Narcotic investigation revealed: *On 10/19/25 at 6:30 p.m. LPN N, RMA L, and RMA J discovered six tablets of resident 3's clonazepam ODT 0.25 mg were missing during the controlled medication count. *LPN N, RMA L, and RMA J had searched for the missing clonazepam in both medication carts. *At 6:45 p.m. facility director B was notified of	S 642		

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S 642	Continued From page 25 resident 3's missing clonazepam. -Facility director B instructed the staff to continue the controlled medication count and document the missing clonazepam on the Controlled Drug Receipt/Record/Disposition form, so the count was correct. -Facility director B was notified that the 10/19/25 morning controlled medication count was not completed because RMA K had signed the Narcotic Shift Counting Record and left prior to having completed the controlled medication count with RMA J and RMA J signed the Narcotic Shift Counting Record without having completed the controlled medication count with RMA K. -Facility director B spoke with RMA K, who was unable to explain where resident 3's missing clonazepam was. -At that time facility director B documented, "Since the narcotic count was not completed, the date/time of when the doses went missing is unknown. *On 10/20/25 facility director B documented: -That she and other staff members, "went through both med [medication] carts, including removing all the drawers. We looked through the garbage that hadn't been taken to the dumpster yet and the shred bin, but the medications were not found. Staff believes the medication sleeve may have fallen out of the box when a dose was removed to be given and fell into the garbage can attached to the side of the med cart. Since the garbage has already been removed, this cannot be verified." -The pharmacy was notified of resident 3's missing clonazepam and replacements were ordered at the cost of the facility. -"Due to resident not missing a scheduled dose and the facility covering the costs of the replacement medication, family and physician were not notified as investigation of the	S 642		

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S 642	Continued From page 26 medication did not find concerns for theft." - Administrator A and RN M "have been notified of missing doses and are in agreement with follow-up and conclusion." *The Missing Medication/Narcotic Form included: -The staff who identified that there was a missing medication were LPN N and RMA J. -The clonazepam 0.25 mg was discovered missing on 10/19/25 at 6:45 p.m. -The clonazepam was missing from the locked medication cart. -Resident 3 did not have a bath that day and was not out of the building. -The medication carts, medication bins, nurses station, and the garbage containers had been searched. -The medication was not found. -This form did not include who completed it or when. 4. Interview on 11/5/25 at 12:10 p.m. with LPN I regarding the controlled medication count revealed: *The controlled medications were counted at shift change by the RMA or nurse leaving the shift and the RMA or nurse coming on shift. *The signature of the RMA or nurse would indicate the controlled medication count had been completed and the count of the controlled medications was accurate. *If a controlled medication count was found to be inaccurate facility director B was to be notified and she would instruct the RMA or nurse what to do next. *LPN I stated she had notified pharmacy the day after resident 3's controlled medications were identified as missing. 5. Observation and interview on 11/6/25 at 10:32 a.m. with LPN N revealed:	S 642		

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S 642	Continued From page 27 *All controlled medications were kept in the locked drawer in the second-floor cart. *There were two set of keys that could open the medication carts and the controlled medication drawer. *The two RMAs or nurses on each shift would be in possession of the keys. *Each morning the RMA or nurse who was on the night shift would complete the controlled medication count with the oncoming RMA or nurse who would be administering medications with the second-floor medication cart on the day shift. *After the controlled medication count was completed and verified to be accurate the RMAs or RMA and nurse who completed the controlled medication count would sign the Narcotic Shift Counting Record. *On the morning of 10/19/25 LPN N was the nurse on duty. *When LPN N and RMA J arrived for their morning shift on 10/19/25 the keys for the second-floor medication cart were lying on top of the cart. *RMA K was not able to be found to complete a controlled medication count. *On the morning of 10/19/25 a controlled medication count was not completed, even though both RMA K and RMA J had signed the Narcotic Shift Counting Record to indicate the controlled medication count had been completed. *LPN N stated that "99 percent of the time" the night shift tells the oncoming day shift staff that they had already counted the controlled medications. *On 10/19/25 at 6:30 p.m. RMA J and RMA L completed the controlled medication count and found resident 3 was missing six tablets of her clonazepam. *LPN N and RMA J searched for the missing	S 642		

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S 642	Continued From page 28 tablets for over an hour in both medication carts, the garbage, the sharps containers, and anywhere else they thought the medications could have been misplaced. *After resident 3's clonazepam tablets were determined to be missing, facility director B was notified of resident 3's missing clonazepam. *Facility director B instructed LPN N to make a note on the Narcotic Shift Counting Record and update the Controlled Drug Receipt/Record/Disposition form with the corrected controlled medication count. *LPN N removed the box of clonazepam from the medication cart and stated the clonazepam was not in a bubble packed card but rather in the manufacturer's box because it could not be bubble packed due to the oral disintegrating tablets would disintegrate during the bubble packing process. *Within the manufacturer's box there were sheets of foil wrapped tablets. Each sheet had six tablets in it. *The outside of the manufacturer's box indicated there were to be "60 (10 x 6) unit dose tablets" in the box when it was dispensed, and it was box one of one. *LPN N stated that she had interviewed all the staff who were certified to administer medications and only RMA O stated she opened the manufacturer's boxes and counted the controlled medications when she checked the medication in from pharmacy. *LPN N stated that during her interviews of other medication certified staff she was told that at times staff do not count the remaining controlled medications after they administer the medications, rather they just document the next lower number for the controlled medication count on the Controlled Drug Receipt/Record/Disposition Form.	S 642		

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S 642	Continued From page 29 *LPN N stated the pharmacy was notified on 10/20/25 due to it being after pharmacy hours when the missing clonazepam was identified. 6. Interview on 11/6/25 at 11:04 a.m. with RMA J revealed: *RMA J stated when he arrived at work on the morning of 10/19/25 the keys to the second-floor medication cart were unsupervised on top of the cart. *RMA K was not seen by RMA J, so he began administering medications to the residents. *When he was administering a controlled medication to a resident, he realized RMA K had signed the 10/19/25 6:30 a.m. Narcotic Shift Counting Record but he had not, so he signed the Narcotic Shift Counting Record to indicate the count had been completed and accurate even though the count had not been completed and was not verified to be accurate. *RMA J stated there were other times when the controlled medication count was not completed and the off going and on coming staff both signed that it had been completed, but this did not happen often. *When he and RMA L identified there were six clonazepam tablets that were unable to be accounted for, he looked through the medication carts and the garbage containers. He stated he had removed the drawers from the carts to be sure the clonazepam had not fallen under or behind one of the drawers. *After he was not able to locate resident 3's six tablets of clonazepam, he notified LPN N. *RMA J stated he didn't know what happened to result in the six missing tablets of clonazepam. *He stated if it had come from pharmacy with less then the 60 tablets in the box the staff member who checked in the medication from pharmacy would have not counted the medication to verify	S 642		

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S 642	Continued From page 30 the initial medication count was correct. The following seven doses administered would have been administered by five different staff members without counting to be sure the correct amount of medications were present. 7. Interview on 11/6/25 at 11:38 a.m. with registered nurse (RN) M revealed: *She stated the controlled medication count was to be completed between each change of shift by the oncoming nurse or RMA and the off going nurse or RMA. *If the Narcotic Shift Counting Record was signed by two staff members, she would expect the controlled substance count had been completed and verified to be accurate. *The medication cart keys should always be in constant possession of the RMA or nurse until they are passed on to the next shift. *The medication cart keys having been left unattended on top of the cart provided an opportunity for someone to open the medication cart and access the controlled substances within the locked controlled substance drawer. *She stated the medication cart keys being left unattended on top of the medication cart and staff having signed that the controlled medication shift count has been completed without completing the medication count provided opportunities for drug diversion. 8. Interview on 11/6/25 at 12:47 p.m. with administrator A and facility director B revealed: *Facility director B had been notified of resident 3's missing clonazepam on the evening of 10/19/25. *She verified that staff had searched for the missing clonazepam and then instructed them to document the missing medication on the Missing Medication/Narcotic Form, the Controlled Drug	S 642		

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S 642	Continued From page 31 Receipts/Record/Disposition Form, and the Narcotic Shift Counting Record and then continue with the scheduled medication administrations. *Facility director B searched for resident 3's missing clonazepam and interviewed the involved staff on the morning of 10/20/25. *She verified clonazepam was a controlled substance and at high risk for abuse, addiction, and potential theft. *Facility director B stated she determined resident 3's clonazepam was not stolen because she could not verify that the correct number of tablets were received from the pharmacy. She stated she had been told by the pharmacy, that since the clonazepam came in a manufacturer's box, they did not count the amount of clonazepam in the box even though the box was not sealed. *She stated LPN I had not counted the clonazepam when it arrived from pharmacy because it came in the manufacturer's box. *Facility director B verified resident 3's clonazepam had been checked in from pharmacy by LPN I on 10/15/25 as having been 60 tablets, and the medication was administered seven times by five different staff members before the controlled medication count identified the missing clonazepam. *She stated she did not think it was theft because resident 3's clonazepam was not a new medication, the staff involved were established staff, and resident 3 was an established resident. *Facility director B was notified that the controlled medication count had not been completed on the morning of 10/19/25 by RMA K and RMA J and the keys to the medication cart were left unattended on the medication cart. *Facility director B and administrator A had not reviewed the video monitoring to determine if the medication cart had been accessed by an unauthorized person while the keys were left	S 642		

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S 642	Continued From page 32 unattended on top of the medication cart. *Facility director B verified by leaving the keys unattended on the medication cart, it posed an increased risk for drug diversion. *Facility director B and administrator A stated they were not aware: -Staff were documenting that they had completed the controlled medication count but were not completing it. -Staff were not counting the medications that remained in the package after having administered a controlled substance, but rather just writing down the next lower number. *Facility director B agreed she was not able to prove the medication had not been stolen from resident 3. *She verified she was unable to determine when the medication had gone missing due to the controlled medication counts not being completed between each shift, LPN I having not counted upon receipt of the medication, and staff not counting the remaining medications after the medications were administered. Review of the provider's April 2025 Delivery Service process revealed: *"Receiving Medications During the daily delivery process, each tote will be sealed with a zip tie. Upon arrival, totes will be unlocked, and the medication should be reviewed for accuracy & [and] compared to the accompanied packing slip." *"All controlled substances will be enclosed in a sealed plastic bag, which facility staff will open and reconcile. Each controlled substance will be accompanied by a medication count sheet." Review of the provider's 1/11/24 Administration and Control of Narcotic policy revealed: *"Storage and Distribution of Narcotics	S 642		

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S 642	Continued From page 33 a. Lock narcotics in the narcotic cupboards/carts at each nursing station. Narcotics should be double locked." *"Administration and Documentation a. The registered nurse or licensed nurse completes the Narcotic Administration Record for each dose administered. This includes: i. Time of administration ii. Patient's last name and first initial iii. Dosage of narcotic administered iv. Physicians' last name and first initial v. The number of units of narcotics remaining vi. Amount of narcotic wasted, if applicable vii. Signature of the registered or licensed nurse of Med Aide administering the medication and/or observing wastage viii. Make all entries in ink." *"Counting Narcotics a. Count narcotics at the change of each shift or change of staff b. The minimum requirement is to count every 12 hours. c. Two registered or licensed nurse/Medication Aide will count the narcotics using the Narcotic Counting Record." *"Missing Doses a. Rule out all sources of discrepancy b. Inform the Nurse and/or Director of Assisted Living Facility. c. Indicate the missing dose on the Narcotic Administration Record d. Complete a Missing Medication/Narcotic Form indicating a dose is missing".	S 642		
S 652	44:70:07:06 Drug Disposal Medications controlled under SDCL chapter 34-20B may not be returned to the dispensing pharmacy or to an authorized reverse distributor	S 652	Facility's *Medication Disposal Policy* was reviewed and revised to include disposal route documentation. Education will be provided by Director of Assisted Living by 12/21/25 for all licensed nursing staff and	12/21/25

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S 652	Continued From page 34 company. Documentation of destruction or disposal of medications must be included in the resident's record. The documentation must include the method of disposition (destruction, disposal, or return to pharmacy); the medication name, strength, prescription number (as applicable), quantity, and date of disposition; and the name of any person who witnessed the destruction or disposal. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure the disposition of medications removed from use were documented for two of two (2 and 5) sampled residents with discontinued medication. Findings include: 1. Interview on 11/5/25 at 12:10 p.m. with licensed practical nurse (LPN) I regarding the provider's medication disposal process revealed: *If a medication was discontinued or expired the medication would be removed from use and a Medication Disposition Sheet would be completed to document the disposal of the discontinued or expired medication. *The Medication Disposition Sheet included the resident's name, the date, the prescription number, medication name, strength of the medication, quantity of the medication, a key for disposition, a column for reason, and two locations for signatures and date for the staff member completing the form and a witness. - The "Key: Disposition Reasons	S 652	medication aides on the *Medication Disposal Policy.* Director of Assisted Living or designee will audit Medication Disposition Sheets weekly for one quarter, then monthly thereafter, for compliance and will report findings to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 652	Continued From page 35 A. Medication Discontinued B. Resident Deceased C. Resident Discharged D. Resident in Hospital E. Other (Specify above) Return medications to pharmacy with yellow carbon copy F. Destroyed at Facility G. Released to Resident". *"Instructions: Use this form to record the disposition, destruction and/or return of medication to pharmacy. An entry is required for each medication along with the reason for disposition. A signature of the person completing form and a witness as required. Send the yellow carbon copy with the medication(s) to the pharmacy. Retain the white copy for facility records and store per facility policy." *"[Contracted pharmacy] cannot accept returns of: Controlled Drugs, Hazardous Drugs, Refrigerated Items, or any opened products such as Creams, Inhalers, Powders, Drops". *LPN I stated when she destroyed a medication or sent a medication back to the pharmacy she would complete the Medication Disposition Sheet and enter a progress note into the resident's electronic medical record (EMR) to document the disposition of the medication and the reason for the disposal or return to pharmacy. *LPN I stated that when a resident's medication was returned to the pharmacy a yellow carbon copy of the Medication Disposition Sheet would be sent with the resident's medication. *LPN I explained that the facility had recently began using a bubble pack system for the residents' pills in June 2025 and with this system the facility was able to return those unused medications to the pharmacy. *LPN I stated that prior to the bubble pack system there was no documentation as to the disposition	S 652		

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S 652	Continued From page 36 of the medications when they were returned to the pharmacy. 2. Review of resident 2's Medication Disposition Sheets from August 2025 through October 2025 revealed: *On 8/1/25, 15 furosemide 40 mg [milligrams] tablets (a medication used to treat fluid retention and high blood pressure) were removed from use due to the medication having been discontinued. There was no documentation whether the medication had been destroyed or returned to pharmacy. *On 8/29/25, 37 oxybutynin 5 mg tablets (a medication used to treat overactive bladder) were removed from use due to the medication having been discontinued. There was no documentation whether the medication had been destroyed or returned to pharmacy. *On 9/3/25, 12 furosemide 20 mg tablets were removed from use due to a dose change. There was no documentation whether the medication had been destroyed or returned to pharmacy. *On 10/13/25, 11 Jardiance 10 mg (a medication used to treat diabetes, heart failure, and chronic kidney disease) were removed from use due to the medication having been discontinued. There was no documentation whether the medication had been destroyed or returned to pharmacy. 3. Review of resident 5's Medication Disposition Sheets from July and August 2025 revealed: *On 7/29/25, 7 fluconazole 100 mg tablets (a medication to treat fungal and yeast infections) were removed from use due to the medication having been discontinued. There was no documentation whether the medication had been destroyed or returned to pharmacy. *On 8/14/25, 66 Preservision Areds 2 (a vitamin supplement) capsules were removed from use	S 652		

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S 652	Continued From page 37 due to the medication having been discontinued. There was no documentation whether the medication had been destroyed or returned to pharmacy. 4. Review of resident 2's 10/13/25 Medication Disposition Sheet with LPN I on 11/5/25 at 12:10 p.m revealed there was no documented disposition of the medication. LPN I was unable to determine by the sheet if the medication was destroyed at the facility or returned to pharmacy. *LPN I reviewed resident 2's EMR and verified there was no progress note to indicate whether the medication was destroyed or returned to pharmacy. *LPN I stated it must have been returned to pharmacy, but verified there was no documentation to verify it has been returned to pharmacy. 5. Interview on 11/6/25 at 12:40 p.m. with administrator A and facility director B revealed: *If a medication was to be returned to the pharmacy the Medication Disposition Sheet would be completed, and the yellow carbon copy of that sheet would be sent to the pharmacy with the medication. *All controlled substances were to be destroyed within the facility. *Facility director B stated when two nurses or a nurse and a certified medication aide (CMA) completed the Medication Disposition Sheet she expected the documentation to include the prescription number, the medication, the dose of the medication, the quantity of the medication, why the medication was being removed from use, and the signature of the two staff members who participated in the destruction or return of the medication to the pharmacy. *Facility director B did not expect the Medication	S 652		

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S 652	Continued From page 38 Disposition Sheet to include documentation to whether the medication had been destroyed or returned to pharmacy. *Facility director B stated she was not aware the regulation required the documentation of the disposition of the medication once it was removed from use. *Facility director B and administrator A verified they would not be able to determine if the medication had been destroyed, returned to the pharmacy, or if the medication was illegally removed from the facility without the documentation of the medication disposition. Review of the provider's 1/11/24 Medication Disposal Policy revealed: *"Any medications that are dispensed to the facility must have a record of what was done with it, if no longer ordered." *"Any unopened medications may be returned to Pharmacy excluding medications from the med roll or narcotics." *"If returning medications to pharmacy fill out the disposition sheet and send yellow copy to pharmacy with the medication. White copy stays at facility." *"Document the destruction in the medication disposition binder under resident name (located in the medication room): Including: a. Rx [prescription] number b. Amount of medication destroyed c. Method of destruction (will always be DRUGBUSTER drug disposal system, unless unopened and sent back to the pharmacy."	S 652		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer	S 685	Facility's *Self-Administration Medication Policy* was reviewed and revised to include specifications of facility responsibility and resident responsibilities for self-administration medication orders.	12/21/25

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S 685	Continued From page 39 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 met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure: *Two of two sampled residents (1 and 2) who self-administered medications were assessed for the ability to safely self-administer those medications. *One of two sampled resident (2) had physician's orders to self-administer medications. *The medication self-administration assessments for two of two sampled (1 and 2) residents were completed by a registered nurse (RN). Findings include: 1. Interview and observation on 11/5/25 at 3:10 p.m. with resident 1 revealed: *She was seated in her recliner in her living room. *There was a partially used tube of hydrocortisone cream on the stand next to the recliner.	S 685	Updated self-administered safety assessments for all residents, including resident 1 and 2, completed by facility RN by 12/1/2025, as well as verification from resident providers for up-to-date orders of the approved self-administered medications post-assessment. Education will be provided by Director of Assisted Living by 12/21/25 for all licensed nursing staff on changes to policy and procedure. Quarterly self-administration safety screens will be conducted by the facility RN or RN designee. Director of Assisted Living or designee will audit Self-Administration Medication orders and assessments weekly for one quarter, then monthly thereafter for compliance and will report findings to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 685	Continued From page 40 *She stated she used the hydrocortisone cream regularly. Review of resident 1's electronic medical record revealed: *She was admitted on 6/9/25. *There was a 9/5/25 Medication Self-Administration Safety Screening completed. -This screening included the following medications: acetaminophen, AR formoterol tartrate, Budesonide Inhalation Suspension, Ipratropium-Albuterol Nebulizer, and Albuterol HFA Inhaler. -This screen was completed by a licensed practical nurse (LPN). *She had a 10/22/25 physician order for "Hydrocortisone External Cream 1 % (Hydrocortisone (Topical)) Apply to Wrist topically every 12 hours as needed for Rash unsupervised self-administration *may keep at bedside*." -There was no Medication Self-Administration Safety Screening completed for the hydrocortisone cream. 2. Interview on 11/5/25 at 4:00 p.m. with resident 2 in her room revealed: *Resident 2 stated she had had medication in her room, but staff recently came into her room and removed them. *She was told she did not have an order for the medication. *Resident 2 stated she did have an order for her eye drops and staff removed them from her room. *She stated she had been taking her eye drops three times per day, but she did not get them that morning because they had been removed from her room. *Resident 2 stated she wanted her lotions, eye drops, and cough drops in her room so she could	S 685		

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S 685	Continued From page 41 take them when she wanted. Review of resident 2's electronic medical record (EMR) revealed: *She was admitted on 10/25/24. *The 10/24/24 physician's order for "Psyllium Husk Powder (Psyllium Husk (Bulk)) Give 1 Tbsp [tablespoon] by mouth one time a day for constipation ...unsupervised self-administration". *The 7/17/25 physician's order for "hydrocortisone cream 1 %: Apply to affected area PRN [as needed] BID [two times a day], May keep @ [at] bedside." *On 10/17/25 a physician's order was received to discontinue the hydrocortisone cream due to resident 2 applying the cream, "on her toe with the diabetic ulcer and other areas that are inappropriate". *There was an 8/13/25 physician's order to start "Systane, Blink, or Refresh [eye drops used for dry eyes] 1 gtt [drop] TID-QID [three times daily to four times daily]". -The physician's order did not include which eye the eye drop was to be used in and it did not include that the eye drop could be self-administered. *The 8/13/25 physician's order entered into resident 2's EMR was, "Blink Tears Ophthalmic Solution 0.2% (Polyethylene Glycol 400 (Ophth)) Instill 1 drop in both eyes three times a day for Dry Eyes unsupervised self-administration". *The 10/21/25 physician's order for "Menthol Cough Drops Mouth/Throat Lozenge (Throat Lozenges) Give 1 drop by mouth every 4 hours as needed for Cough" did not include a physician's order for self-administration. *There was one Medication Self-Administration Safety Screen completed on 8/13/25 in resident 2's EMR. *The Medication Self-Administration Safety	S 685		

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S 685	Continued From page 42 Screening was completed on 8/13/25 for the self-administration of Blink eye drops and did not include an assessment for the safety of self-administration of the hydrocortisone cream, Metamucil, or cough drops. *The question in the safety screening which stated, "Can state the appropriate situations for self-administration of PRN medications" was answered as not applicable. *The question in the safety screening which stated, "The resident can apply topical ointments, creams, or trans-dermal patches according to MD [medical doctor] orders" was answered as not applicable. *The 8/13/25 Medication Self-Administration Safety Screening was completed by LPN N. 3. Interview on 11/5/25 at 4:13 p.m. with LPN I revealed: *LPN I stated the eye drops had been removed from resident 2's room because she did not have a physician's order for the self-administration of the eye drops and the current physician's order for administration was missing instructions. *The cough drops, and Metamucil had a physician's order for self-administration, but she could not recall if the cough drops were removed because they were expired or resident 2 was no longer using them. *LPN I verified there was no documentation in resident 2's electronic medical record that indicated when or why the medications had been removed from the room. *LPN I stated she had witnessed resident 2 improperly self-administering her eye drops as she was putting the drops on her cheek rather than in her eye. *LPN I stated if a resident expressed interest in self-administering their medications a physician's order would need to be obtained for unsupervised	S 685		

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S 685	Continued From page 43 self-administration of medications in order for the medications to be left in the resident's room. There needed to be an assessment completed which identified which medications were able to be safely self-administered, and those assessments needed to be repeated quarterly to determine if the resident remained safe to self-administer their medications. *Every Sunday the nurse or certified medication aide (CMA) was to check the medications in each residents' rooms for outdates, and to determine if a medication needed to be reordered. 4. Interview on 11/6/25 at 1:23 p.m. with administrator A and facility director B revealed: *If a resident expressed a desire to self-administer medications a Medication Self-Administration Safety Screening assessment would be completed by a nurse. *If the resident was determined to be safe to self-administer medications the nurse would request a physician's order for unsupervised self-administration of medications, which would allow for the resident to keep the medications in their room. *The Medication Self-Administration Safety Screening assessment was to be completed quarterly for all residents who self-administer medications to determine if the resident remains safe to self-administer the identified medications. *The Medication Self-Administration Safety Screening assessment was to identify which medications were being evaluated for the resident to safely self-administer. If an additional medication order was received from the physician for self-administration, another Medication Self-Administration Safety Screening assessment would need to be completed to be sure the resident was able to safely self-administer the new medication.	S 685		

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S 685	Continued From page 44 *Administrator A and facility director B verified a new Medication Self-Administration Safety Screening should have been completed after resident 1 was prescribed hydrocortisone cream for self- administration before she was provided that medication to keep in her room. *Facility director B verified resident 2's 8/13/25 Medication Self-Administration Safety Screening assessment was for her Blink eye drops and did not include hydrocortisone cream, cough drops, or Metamucil. *Facility director B verified there was not a Medication Self-Administration Safety Screening assessment for resident 2 completed initially or quarterly for the hydrocortisone cream, cough drops, or Metamucil. *Facility director B verified resident 2's medication administration record indicated the Blink eye drops were ordered to be self-administered but there was no physician's order for the self-administration. *Facility Director B stated the LPNs completed the Medication Self-Administration Safety Screening assessment. *Administrator A and facility director B stated they were not aware the provider's policy and regulation required the Medication Self-Administration Safety Screen assessment to be completed by a registered nurse (RN). Review of the provider's undated Self-Administration policy revealed: *"If a resident is deemed cognitively, physical, and visually able to self-administer medications by the facility administrator and physician and wises [wishes] to do so, the following responsibilities are to be followed: Resident Responsibilities: 1. Must be able to state name, dose, frequency, and reason for each medication being taken.	S 685		

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S 685	Continued From page 45 2. Inform nursing staff of new or changed medication orders. 3. Reorder medications per self or notify staff at least 3 days in advance. 4. Store medications in a safe manner consistent with manufacturer's recommendations. 5. Inform nursing staff when they have taken the medication. Family Responsibilities: 1. Notify staff of any concerns regarding self-administration of medications. 2. Inform nursing staff of new of [or] changed medication orders Staff Responsibilities: 1. LPN nursing staff responsible for reviewing medications in apartment monthly. 2. RN to evaluate continued appropriateness of the resident's ability to self-administer medications at least every three months." Review of the provider's undated Resident Handbook revealed: *"Medications are managed by trained personnel and under a physician's direction. Medications MAY NOT be kept in a resident's apartment unless specified by a physician's order and after a nursing assessment."	S 685		
S 800	44:70:09:04 Notification When Resident's Condition Change A facility shall immediately inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and, if known, notify the resident's legal representative or interested family member when any of the following occurs: (1) An accident involving the resident that results	S 800	Facility's *Physician Notification Policy* was reviewed and revised to update facility responsibility and staff documentation follow-up for changes in resident condition, including changes and/or injuries to resident skin and timeframe guidelines for various types of resident change. Education will be provided by Director of Assisted Living by 12/21/25 for all licensed nursing staff and medication aide staff on changes	12/21/25

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S 800	Continued From page 46 in injury or has the potential for requiring intervention by a physician, physician assistant, or nurse practitioner; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure: *The primary care provider and family were notified promptly of a newly identified open wound for one of one (2) sampled resident. *The primary care provider was notified of a change in resident's condition and a skin tear for one of one (4) sampled resident. 1. Interview on 11/5/25 at 4:00 p.m. with resident 2 revealed: *She had been told that her toe was going to be removed soon due to a sore on the toe on her left foot. *She felt it had taken a long time to get the surgery scheduled but was not able to recall when the sore on her toe started. Review of resident 2's electronic medical record (EMR) revealed: *Resident 2 was admitted on 10/25/24. *She had a diagnosis of diabetes (a condition involving disruptions in how the body regulates blood sugar) and dementia (a group of symptoms affecting memory, thinking, and social abilities). *Resident 2 had been seeing a podiatrist for a diabetic foot ulcer (open sore or wound on the foot of someone with diabetes which often results	S 800	to policy. Director of Assisted Living or designee will audit resident charts for notification documentation weekly for one quarter, then monthly thereafter, for compliance and will report findings to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 800	Continued From page 47 due to lack of feeling in the foot, poor circulation, pressure, or trauma) on her left second toe. *She was scheduled to have her left second toe surgically removed. *On Tuesday 10/7/25 there was a progress note written by licensed practical nurse (LPN) N that stated, "I informed [resident 2's son] that [resident 2]'s left second toe looks infected. It opened up over the weekend and looks worse today than it did yesterday. I think [resident 2] should be seen by a provider." *There was no documentation in resident 2's EMR of an assessment of the open area on her left second toe to determine when it had opened. *There was no documentation in resident 2's EMR that resident 2's family had been notified of open area until 10/7/25. *There was no documentation in resident 2's EMR that her primary care provider had been notified of the open area on resident 2's left second toe until 10/8/25, when her family took her in to be seen by her primary care provider. Interview on 11/6/25 at 10:21 a.m. with LPN N revealed: *LPN N stated when a skin issue is identified a nurse was to document in the resident's EMR the appearance and location of the sore, notify the resident's family, and notify the resident's primary care provider. *LPN N verified there was no documentation in resident 2's EMR that resident 2's son had been notified of the open area on her left second toe prior to LPN N notifying him on 10/7/25. *She stated resident 2's son visited her every day, so she thought he had been notified of the open area on resident 2's left second toe when it first opened, but she was unable to locate documentation to support that. *LPN N verified the open sore on resident 2's foot	S 800		

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S 800	Continued From page 48 had been open for multiple days prior to LPN N having notified resident 2's son. *LPN N was not able to recall how she knew that resident 2 had an open sore on her left second toe. *LPN N verified there was no documentation in resident 2's EMR that indicated her primary care provider had been notified of the development of the open sore on resident 2's left second toe. *She stated resident 2's primary care provider should have been notified the day the open sore was first identified. *She stated resident 2's primary care provider should have been notified again when the condition of the open sore worsened, but there was no documentation that the primary care provider was notified of the decline in the condition of the open sore. *LPN N stated she was unable to determine how many days resident 2's left second toe had a sore on it before her son or her primary care provider was notified as there was no documentation in resident 2's EMR related to when the open sore was initially identified or the appearance of the open sore. 2. Review of resident 4's care record revealed: *His admission date was 4/13/23. *On 9/2/25, a nurse's progress note indicated that resident 4 was outside, struggling to stay on his feet, and was breathing heavily. Other residents, sitting outside in the same area, reported he had a "hard time walking". He obtained a skin tear to his "left elbow on the edge of a brick by the front door. [Resident 4's] wound was cleaned with 0.9% sodium chloride and 4X4s. Triple antibiotic was applied, a 2 in x 3 in non-adherent pad was placed, and his elbow was wrapped with Kerlix and taped. *There was no documentation that his physician	S 800		

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S 800	Continued From page 49 had been notified of the incident. Interview on 11/6/25 at 10:11 a.m. with facility director (FD) B regarding the 9/2/25 progress note of resident 4's incident revealed: *There was no documentation to support that resident 4's primary care provider was notified of his change of condition and skin tear. 3. Interview on 11/6/25 at 11:45 a.m. with registered nurse (RN) M revealed: *She expected that when an open sore was identified the nurse on duty would enter a progress note related to the open sore's location and appearance. *She also expected that nurse would notify the resident's primary care provider and family of the open sore. *RN M stated the assessment of the open sore, the family notification, and the primary care provider notification was to be documented in the resident's EMR. 4. Interview on 11/6/25 at 1:44 p.m. with administrator A and facility director B revealed: *They expected the staff member who identified an open sore to report the concern to the nurse on duty immediately. *The nurse would then evaluate the open sore and document the evaluation in the resident's EMR. *Upon completion of the evaluation of the open sore, the nurse would notify the resident's family and primary care provider. *The evaluations of the open sore and the notification to the primary care provider and the family was to be completed on the day it was first identified. *Facility director B verified there was no documentation in resident 2's EMR of an	S 800		

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BETHESDA TOWNE SQUARE	1425 15TH AVENUE SE ABERDEEN, SD 57401

(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 800	Continued From page 50 evaluation of the open sore on resident 2's left second toe. *Facility director B verified there was no documentation of resident 2's family or her primary care provider having been notified on the day when the open sore was initially identified. *She verified the date in which the sore was initially identified could not be determined due to no documentation of the open sore on resident 2's left second toe until the progress note on 10/7/25 which indicated it had opened over the weekend. *Facility director B agreed there potentially was a delay in treatment of resident 2's diabetic foot ulcer due to the primary care provider not having been notified immediately after the open sore when it was initially identified. Review of the provider's 11/8/24 Skin Assessment Policy revealed: *"Policy: The purpose of this guideline is to provide a consistent process for accurate and complete wound identification, prevention, management and care." *"The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are- Complete -Accurately documented -Readily accessible -Systematically organized", *"The clinical record must contain enough information to show the facility knows the status of the individual, has adequate plans of care, and provides sufficient evidence of the effects of the care provided. Documentation should provide a clear picture of care provided to resident in contingency to physician orders." Review of the provider's 3/3/25 Physician Notification Policy revealed:	S 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11040	A. BUILDING: _____ B. WING _____	C 11/06/2025

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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 800	Continued From page 51 *"It is the policy of this facility to timely notify the physician, physician's assistant, nurse practitioner or clinical nurse specialist of changes in resident condition." *"'Promptly' means that results shall be relayed with little or no delay to the ordering physician, physician's assistant, nurse practitioner, or clinical nurse specialist." *"The facility must promptly notify the attending physician, physician's assistant, nurse practitioner, or clinical nurse specialist of changes in resident condition that fall outside the 'normal' range for that specific resident, in accordance with facility policies and procedures. Delayed notification may contribute to delays in changing the course of treatment or care plan." *"Document notification of results and condition (date, time, name of individual reported to, new orders if applicable)." *"Notify and document notifications to resident representative, if applicable."	S 800		