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
	10699	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAKOTA SUN ASSISTED LIVING II INC	125 W. 2ND ST VOLGA, SD 57071

(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 10/7/25 through 10/9/25. Dakota Sun Assisted Living II INC was found not in compliance with the following requirements: S285, S295, S296, S400, S443, S474, S477, S506, S630, S670, and S685.	S 000		
S 285	44:70:04:03 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Personnel on duty must be awake at all times, except as provided in § 44:70:03:02.01. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or personnel on contract. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to document that background or reference checks were performed for five of five employees reviewed (B, C, D, E, and F). Findings include: 1. Review of employee records for employees B, C, D, E, and F revealed no record that a background or reference check was completed.	S 285	A background /reference check policy was developed and adopted on 11-10-25. A checklist that includes background/reference checks, TB risk assessment, TB two step skin test and personnel health program to screen for reportable communicable diseases will be used to ensure that all requirements are met per the administrative rule. The administrator, assistant administrator or one designated employee will be responsible for the completion of reference and or background checks before the applicant is hired. This information will be documented either in the EMR under " Staff certifications" or in a paper personnel file. A QA committee consisting of the administrator, the assistant administrator and one designated employee will meet monthly to audit employee files for completion for 6 months. After 6 months, the QA committee will determine if audits should continue or can be discontinued. As of 11-10-25, Employees B, C, D, and F have had reference checks completed to check for history of abuse and neglect. with documentation made in the EMR under "Staff Certifications"	11/10/25

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

Bev Cotton RN/ Administrator 10-30-25

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S 285	Continued From page 1 2. Interview on 10/8/25 at 9:59 a.m. with administrator A revealed that she did not perform official background checks on newly hired employees. She would call the applicant's references, but she did not document any of those conversations.	S 285		
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 personnel record review, interview, and policy review, the provider failed to ensure one of two employees reviewed (E) completed the required annual retraining. Findings include: 1. Review of employee E's personnel file revealed that she was hired on 9/3/23 as a "caretech." There was no documentation that she completed the required annual retraining in 2024 on emergency preparedness and procedures, infection prevention and control, accident prevention and safety procedures, resident rights, confidentiality, mandatory reporting, nutrition risks and hydration, abuse and neglect, and problem solving and communication techniques. 2. Interview on 10/9/25 at 11:41 a.m. with administrator A revealed she confirmed that employee E did not complete the required annual	S 295	Dakota Sun is unable to correct deficient practice for missing annual 2024 education for Employee E as she reigned of her position as of 4-24. Employee E has been notified that if she wished to continue unscheduled part time employment at Dakota Sun, she would need to complete the required annual education topics prior to working her next shift. "Dakota Sun Assisted Living Orientation and Annual Training Requirements" policy was reviewed and revised by the QA committee, consisting of the Administrator, the assistant administrator and one designated employee to include all required training topics as described in ARSD 44:70:04:04. The Administrator or Assistant Administrator will audit all employee files for completion of the required annual training topics, using a checklist and/ or reviewing the corresponding quizzes. This will be completed by the end of the calendar year 2025 and annually thereafter.	11/23/25

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S 295	Continued From page 2	S 295		

retraining. She was responsible for ensuring staff completed the mandatory education upon hire and annually. There was a binder with the required training topics. Staff were to review the binder, take the quiz on each topic, and she was to review those quizzes to ensure they understood each topic, but that had not occurred.

3. Review of the provider's undated "Dakota Sun Assisted Living Orientation and Annual Training Requirements" policy revealed that the policy listed eight of the eleven required topics in the "mandatory training" section. That section did not include nutritional risks and hydration needs of residents, abuse and neglect, and education based on resident care needs.

The policy required training to be completed within 30 days of hire, and annually thereafter.

Under the "Additional Training Recommendations" section, "While not mandated by state law, the South Dakota Association of Healthcare Organizations (SDAHO) recommends additional training topics to enhance staff competence and care quality: elder abuse prevention, cultural competency, working with an aging population, assisting with oral hygiene, nutrition and meal preparation, and introduction to dementia care."

The policy indicated that the provider "will maintain documentation of all training sessions, including: date and time of training, instructor's name and qualifications, a brief description of the training content, [and] staff member's written signature acknowledging completion."

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S 296	Continued From page 3	S 296	Employee B completed the required training topics as of 10-10-25. Employees C and D will complete the required training topics by 11-15-25. The "Dakota Sun Assisted Living Orientation and Annual Training Requirements" policy was reviewed and revised by the QA committee consisting of the administrator, the assistant administrator, and one designated employee to include all required training topics as described in ARSD 44:70:04:04. A checklist will be developed to ensure that all new employees follow the same program which will include some videos, handouts and hands-on training. The training will happen within 30 days of hire and ongoing as needed until the employee feels comfortable performing the duties independently. The checklist will be completed by 11-15-25 as a joint effort with the QA committee. The QA committee will meet on 11-14-25 to review employee files for completion. The administrator, assistant administrator or designee will complete monthly audits of all new employee files for completion of the required orientation training topics for 6 months. After 6 months, the QA committee will determine if audits should continue or discontinue.	11/15/25
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by:	S 296		

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S 296	Continued From page 4 Based on employee personnel record review, interview, and policy review, the provider failed to ensure three of three newly hired employees (B, C, and D) completed the required initial training within 30 days of hire. Findings include: 1. Review of employee B's personnel file revealed that she was hired on 1/3/25. She started out as a cook and later transitioned into the "caretech" position. There was no documentation that she completed the following required training topics within 30 days of hire: resident rights, confidentiality, mandatory reporting, nutrition risks and hydration, abuse and neglect, problem solving and communication techniques, and education based on resident care needs. 2. Review of employee D's personnel file revealed that she was hired on 9/9/25 as a housekeeper. There was no documentation that she completed any of the required training topics within 30 days of hire. Interview on 10/7/25 at around 11:30 a.m. with employee D revealed that she started at the facility about a month ago as a housekeeper. She confirmed there was no formal training when she started. 3. Review of employee C's personnel file revealed that she was hired on 7/2/25 as a cook. There was no documentation that she completed any of the required training topics within 30 days of hire. 4. Interview on 10/9/25 at 11:41 a.m. with administrator A revealed she confirmed that employees B, C, and D did not complete the initial	S 296		

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S 296	Continued From page 5 training within 30 days of hire. She was responsible for ensuring staff completed the mandatory education upon hire. There was a binder with the required training topics. Staff were to review the binder, take the quiz on each topic, and she was to review those quizzes to ensure they understood each topic, but that had not occurred. 5. Review of the provider's undated "Dakota Sun Assisted Living Orientation and Annual Training Requirements" policy revealed that the policy listed eight of the eleven required topics in the "mandatory training" section. That section did not include nutritional risks and hydration needs of residents, abuse and neglect, and education based on resident care needs. The policy required training to be completed within 30 days of hire, and annually thereafter. Under the "Additional Training Recommendations" section, "While not mandated by state law, the South Dakota Association of Healthcare Organizations (SDAHO) recommends additional training topics to enhance staff competence and care quality: elder abuse prevention, cultural competency, working with an aging population, assisting with oral hygiene, nutrition and meal preparation, and introduction to dementia care." The policy indicated that the provider "will maintain documentation of all training sessions, including: date and time of training, instructor's name and qualifications, a brief description of the training content, [and] staff member's written signature acknowledging completion." 6. Review of the provider's undated "Dakota Sun	S 296		

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S 296	Continued From page 6 Assisted Living policy on orientation and training" revealed that staff were to complete the "structured orientation and training program before assuming their regular duties." The orientation program was a review of the employee handbook that included the required topics of infection control, resident rights, accident prevention and safety procedures, infection prevention and control, confidentiality, abuse and neglect, and mandatory reporting procedures. The "initial training program ...within the first 30 days ...may include: medication administration (if applicable), assistance with activities of daily living (ADLs), proper lifting and transfer techniques, fall prevention strategies, nutrition and hydration support, dementia and Alzheimer's care, fire safety and evacuation drills, [and] use of facility equipment and technology."	S 296		
S 400	44:70:05:01 Nursing Policies And Procedures The facility shall establish and maintain policies and procedures that provide nurses and other healthcare personnel with methods of meeting the facility's administrative and technical responsibilities in providing care to residents. The policies must include: (1) The noting of diagnostic and therapeutic orders; (2) The assignment of the nursing care of residents; (3) Administration and control of medications; (4) Assessment and documentation by nurses; (5) Documentation by healthcare personnel; (6) Infection control;	S 400		

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S 400	Continued From page 7 (7) Resident safety; (8) Delineation of orders from nonphysician practitioners; and (9) Activities of daily living to maintain each resident's physical functioning and personal care. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to follow their incident policy for reporting and investigating resident incidents related to resident 4's bruise of unknown origin and resident 2's falls. Findings include: 1. Review of resident 4's closed electronic care record revealed a progress note from the evening of 1/18/25 that read, "We had mostly a good evening other [than] it took lots of convincing [resident 4] to change into pajamas. Then she [resident 4] was sleeping in her bed and when I [caretech K] checked on her about 20 minutes later she was in her chair. Tried to get her back into her bed and she was not having that, didn't want [anything] to do with that whatsoever. There was no moving her no matter what I tried." On 1/19/25, a progress note read, "Upon trying to get [resident 4] ready this morning we went to the bathroom and I [caretech H] noticed a fairly good sized, very dark bruise on [resident 4's] left hip. [Administrator A] notified. I [Caretech H] gave her [the] morning Tylenol right away as she was angry [and] in pain." Administrator A assessed the bruise and received report from a staff member about resident 4	S 400	Unable to investigate resident 4's bruises as she has since discharged. Unable to investigate resident 2's fall from 6-3-25 due to timing of the event from several months ago. The "Incident Reporting Policy" was reviewed and updated as of 11-11-25 to include incident reporting instructions, notification guidelines (including to the SD DOH, Dept of Human Services and law enforcement) and to include not only falls but also injures (such as a bruise) of unknow origin that are found. A step-by-step instructions sheet to guide the employee on how to complete an incident report in the EMR was created. This includes what to report, who to contact, and details of what was found. Per policy when an incident report is made using the EHR a notification will be sent to both administrator and assistant administrator at which time the RN/Administrator will review the incident to determine if further investigation needs to be completed. A QA committee consisting of the administrator, assistant administrator and one designated employee have reviewed and revised the current "Incident Investigation Policy to outline incident investigation guidelines. The Administrator will be responsible for reporting to the SD DOH. Administrator or designee will educate all staff about the revised policies and incident reporting tutorial by 11-15-25. Confirmation of all employees who received education will be obtained and documented in the employee's file in the EHR or in their personnel folder. Administrator or designee will review EHR charting weekly x 6 weeks, then monthly x 2 months to ensure compliance with reporting and investigating guidelines. Administrator or designee will report findings to QA committee for recommendations to continue or discontinue the audits.	11/23/25

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S 400	Continued From page 8 continuing to experience pain. Administrator A's progress note read, "The [bruised] area does look a little swollen but I could not palpate [feel] any other deformity." There was no documentation that the cause of the bruise was investigated, such as interviewing the staff from the evening and night shift from 1/18/25 to see if there were any unreported behaviors or accidents, interviewing cognitively intact residents about any care concerns, or interviewing resident 4 about what happened. Interview on 10/8/25 at 3:26 p.m. with administrator A revealed that she assumed the bruise was from an unwitnessed fall, but she could not verify that. She notified resident 4's son about the resident's bruise. She confirmed there was no investigation of the cause of resident 4's bruise. 2. Review of resident 2's electronic care record revealed a progress note written by administrator A from 6/3/25 that read, "[resident 2] has been very confused and agitated. She has had an ongoing UTI [urinary tract infection] for the last month. Just started on Cipro [ciprofloxacin, an antibiotic] for the 3rd [third] time on Thursday. This morning she also had a fall. Wondering if something else is contributing to her confusion. No labs other than UA [urinary analysis] has been done." There was no other documentation in her electronic care record related to an investigation on that fall. Interview on 10/9/25 at 10:26 a.m. with administrator A revealed that if a resident fell, she expected staff to notify her, the resident's family,	S 400		

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S 400	Continued From page 9	S 400		

and the resident's primary care provider. Staff were to enter an incident note in the resident's electronic care record describing the resident's fall. Since administrator A was a registered nurse, she would assess the resident if she were present at the facility at the time of the fall. If she was not at the facility, she expected staff to call her and she would come to the facility to assess the resident.

Administrator A confirmed that an incident note was not entered for resident 2 when she fell on 6/3/25, and a fall investigation was not completed. She could not remember details of the resident's fall.

3. Review of the provider's undated Incident Reporting Policy revealed:
*"Injury and unusual incidents will be reported in compliance with state regulatory requirements.
*Procedure:
-1. The Unusual Incident form is used to document and report any incident which is a threat to a resident's health, safety, welfare, or rights. This includes, but is not limited to occurrences such as:
--a. Falls.
--b. Injury.
-- ...f. Any incident that threatens the health, welfare, or safety of the resident.
-2. Any incident which is a threat to a resident's health, safety, welfare, or [rights] will be reported to the state licensing agency within 7 days of the incident and a report made via telephone within 24 hours of the incident.
-3. The resident staff care taker fills out the incident report form with the Administrator and RN to review and complete.
-4. Incidents are reported to the resident's responsible party. Document the date and time

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S 400	Continued From page 10 the report was made to the family/responsible party in the narrative charting section. -5. All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman, state licensing agency, and in the case of assault (physical or sexual) to law enforcement. -6. All falls must be reported to the Dept [Department] of Health via designated website."	S 400		
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (1 and 4) had a cognitive screening completed at the time of their admission, and two of two sampled residents (2 and 3) had an annual cognitive screening completed. Findings include: 1. Review of resident 3's electronic care record revealed she was admitted on 1/11/21. An evaluation of resident needs was completed on 7/10/24 and 6/5/25. There was no documentation that a cognitive screening was completed. Phone interview on 10/7/25 at 2:45 p.m. with administrator A revealed she said, "I'll be honest and some of them [the evaluations] are not going	S 443	Dakota Sun is currently using a MSQ (Mental Status Questionnaire) that is found on the Residex EHR, which is an EHR built for assisted living facilities. Residents 1, 2, 3 and 4 all had their MSQ completed on 11-7-25. The MSQ will be completed upon admission, yearly and after a significant change in condition to determine the appropriateness of a resident remaining in the facility based on Dakota Sun's capabilities to meet the needs of the resident. The QA committee consisting of the administrator, the assistant administrator and one designated employee has created and adopted a Resident Cognitive Screening policy which outlines the use of the MSQ for cognitive screening. The cognitive screening will be done by a licensed nurse at least upon admission, yearly and after a significant change in condition. The Administrator and the assistant administrator will audit 5 resident care records monthly x 3 months for cognitive screening completion. After 3 months of audits, data will be shared with the QA committee to determine whether to continue or discontinue the audits.	11/23/25

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S 443	Continued From page 11 to be up to date." She explained that she had been working on the floor to fill in for multiple shifts and had not had the time to complete resident evaluations. Resident 3 was non-verbal and the cognitive screening they used required residents to answer questions like "What are the date, month, and year?" She was not aware of a validated cognitive screening tool for residents who were non-verbal. 2. Review of resident 2's electronic care record revealed she was admitted on 5/17/21. An evaluation of resident needs was completed on 7/10/24, 1/30/25, and 5/28/25. There was no documentation that a cognitive screening was completed. Interview on 10/9/25 at 9:15 a.m. with administrator A revealed that she had not been completing the cognitive evaluation questions with resident 2 because she was more non-verbal on the days of the resident needs evaluations. She did not document the reason for deferring the cognitive screening or that it was reattempted. 3. Review of resident 4's electronic care record revealed she was admitted on 1/10/25. Her admission assessment indicated the cognitive screening was "deferred on admit." There was no documented explanation of why the screening was deferred or if it was attempted again. Interview on 10/9/25 at 10:14 a.m. with administrator A revealed that resident 4 refused to answer many of the admission questions, but she did not document that. She did not reattempt the cognitive screening until 2/10/25. 4. Review of resident 1's electronic care record revealed she was admitted on 5/15/25 and there	S 443		

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DAKOTA SUN ASSISTED LIVING II INC	125 W. 2ND ST VOLGA, SD 57071

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S 443	Continued From page 12 was no documentation that a cognitive screening was completed. Interview on 10/9/25 at 10:42 a.m. with administrator A confirmed she did not complete resident 1's admission cognitive screening. 5. Review of the provider's undated Evaluation of Residents policy revealed: *"An evaluation of each resident's care needs will be completed within one week of admission, then 30 days after admission and annually, or as needed based on the physical or mental status of the resident according to Dakota Sun's license of optional services provided." *The policy did not reference the required cognitive screenings.	S 443		
S 474	44:70:06:08 Written Dietetic Policies The facility shall have written policies and procedures that govern all dietetic activities. The policies and procedures must include food handling procedures, length of duration for leftovers, and opened packages of commercially prepared food in accordance with chapter 44:02:07. The facility shall review the policies and procedures yearly and revise as necessary. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to have a policy and procedure related to food procurement and the acceptance of meat and fish from unapproved sources. Findings include:	S 474	The fish was brought in by a family member without the knowledge of the administrator After informing the family member that Dakota Sun was not able to use the fish that was brought in. The family requested that we save the fish and return it to them as they were going to be back at the facility that weekend. The fish was returned to the family at that time. A new policy has been made to direct employees on food procurement. This policy will be printed so that all employees will be able to review the policy with acknowledgement obtained and recorded in the electronic staff record and in the paper personnel records Administrator or designee will audit the food storage areas, including the refrigerators, coolers and freezers to ensure foods are from approved sources. Audits will be conducted weekly x 6 weeks. Data will be share with the QA committee to determine further recommendations.	11/23/25

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S 474	Continued From page 13 1. Observation on 10/7/25 at 9:00 a.m. in the kitchen revealed there was a thawed pound of ground beef in the reach-in cooler that was from a local meat locker. The package was labeled with "NOT FOR SALE." There was another pound of ground beef in the reach-in freezer from the same meat locker, with the same label of "NOT FOR SALE." There were at least three grocery bags of frozen fish fillets in vacuum-sealed packages. One of the bags was labeled, "Fish." The packages of fish in that bag were not labeled with what type of fish it was. Another bag was labeled "Walleye." The third bag was labeled "Walleye fish from [resident's name] Daughter 9-28-25." 2. Interview on 10/7/25 at 9:15 a.m. with cook G revealed that the ground beef in the cooler was supposed to have been used that past weekend. She confirmed the beef was from a local meat locker. She confirmed that one of the resident's family members had brought in several bags of fish from a fishing trip and they wanted to serve that fish to the residents. She was not aware that fish donated by the community and meat from the local meat lockers were not approved to have been served at healthcare facilities like assisted living centers. 3. Interview on 10/8/25 at 8:22 a.m. with administrator A revealed that she was aware that food served in healthcare facilities was required to come from approved sources. She confirmed they had no food procurement policy that addressed that.	S 474		

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S 477	Continued From page 14	S 477	Resident 3 and 5's diet order has been clarified as IDDSI Level 6 in collaboration with their primary care physician and dietitian. The policy " Dakota Sun Assisted Living Therapeutic Diets was reviewed and revised to include the needs of residents who require therapeutic diets. Therapeutic diets will be recorded for the resident from the physician orders, documented in the resident EHR, with a copy of the physician orders also kept in the kitchen. Administrator or designee will educate all staff on the therapeutic diets policy. Training records to be documented in employee personnel records. After consulting with Dakota Sun's Dietitian, the assistant administrator has developed a daily template that includes menu extensions for therapeutic diets using the IDDSI levels: Level 7- Regular- easy to chew/NAS/Liberal Diabetic Diets Level 6: Soft and Bite Sized Level 5: Minced and Moist Level 4: Pureed These templates will be reviewed, signed and dated by the dietitian when completed and when changes are made. A QA committee consisting of the administrator, the assistance administrator and one designated employee will meet weekly to review the menus and extensions. for 6 weeks. After 6 weeks. data will be reviewed by the QA committee and dietician to determine if audits should continue. The assistant administrator or designee will email the menu extensions to the dietitian monthly to review, edit and sign.	11/23/25
S 477	44:70:06:09 Written Menus Any regular or therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or dietician. Each menu must be written at least one week in advance. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to have a written menu to provide two of fifteen sampled residents (3 and 5) with their ordered dysphagia (difficulty swallowing) advanced diets. Findings include: 1. Review of the provider's 10/8/25 "Diets including Liquid and Texture" report revealed that residents 3 and 5 received a regular diet with a texture modification of "Dysphagia advanced (soft and bite sized)." 2. Review of the provider's menu binder revealed there were menus for regular, diabetic, and no added salt diets. There was no approved diet for the "Dysphagia advanced (soft and bite sized)" texture modification in that binder. The menu binder included a list of common foods acceptable on the dysphagia advanced diet created by the provider's contracted registered dietitian, but it was not specified to their current menu cycle. 3. Interview on 10/8/25 at 8:22 a.m. with administrator A revealed that she thought the list of commonly accepted foods in the menu binder	S 477		

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S 477	Continued From page 15 was sufficient to serve as their menu extension for the dysphagia advanced diet. For residents 3 and 5, staff would cut food into smaller pieces (like meat and sandwiches), so those residents had an easier time eating those foods. Those residents otherwise received the regular menu food items.	S 477		
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. 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 two of two food-handling employees (caretech B and cook C) received the required dietary training within 30 days of hire.	S 506	Care tech B completed the required dietary training on 10-10-25. Caretch C will complete the required dietary training by 11-15-25. The QA committee consisting of the administrator, assistant administrator and one designated staff member will create as necessary a policy outlining the required dietary in-service training. The policy will include the required training topics, expectations for food handling employees to complete the training within 30 days of hire and annually. A checklist has been made to ensure new hires complete each training topic to be included in their employee file. The assistant administrator or designee is responsible for ensuring all food handling employees complete the required dietary training within 30 days of hire and annually. Assistant administrator or designee will audit all new food- handling employee files x 3 months to ensure training completion. Assistant administrator or designee will audit all other food-handling employee files by the end of the calendar year 2025 to ensure the annual training has been completed. The QA committee consisting of the Administrator, the assistant administrator and one designee with audit data for recommendations on revising the policy 'process and continuing the audits or discontinuing the audit process.	11/15/25

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S 506	Continued From page 16 Findings include: 1. Review of caretech B's training record revealed she was hired on 1/3/25. She had not completed the required dietary training within 30 days of hire. As of the survey exit on 10/9/25, she had not completed any formal dietary training. 2. Review of cook C's training record revealed she was hired on 7/2/25 as a part-time cook. There was no documentation that she had been trained on the required dietary topics within 30 days of hire. As of the survey exit on 10/9/25, she had not completed any formal dietary training. Interview on 10/7/25 at 4:13 p.m. with cook C revealed that she was not aware of any required dietary training. When prompted with some of the required training topics, she confirmed she had not been trained on those topics since starting her job at that facility. 3. Interview on 10/9/25 at 11:41 a.m. with administrator A revealed she confirmed that caretech B and cook C did not complete the required dietary training within 30 days of hire. She was responsible for ensuring staff completed the mandatory education upon hire and annually. There was a binder with the required training topics. Staff were to review the binder, take the quiz on each topic, and she was to review those quizzes to ensure they understood each topic, but that had not occurred.	S 506		
S 630	44:70:07:04 Storage And Labeling Of Medications All medications must be stored in a well illuminated, locked storage area that is well	S 630		

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S 630	Continued From page 17 ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight degrees centigrade. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure medications stored in one of one medication refrigerator were not accessible to unauthorized staff or visitors according to the provider's policy. Findings include: 1. Observation and interview on 10/7/25 at 12:50 p.m. with caretech H revealed that the medication refrigerator located on the floor under the nurse's station did not have a lock on it. Anyone could have opened the refrigerator and accessed the medications stored inside that refrigerator. Insulin and eyedrops were in the refrigerator. Caretech H was not aware that the medication refrigerator should have been locked. 2. Interview on 10/9/25 at 12:04 p.m. with administrator A revealed that she was aware that the above observed medication refrigerator was unlocked and able to be accessed by anyone. She was aware that medication refrigerators should have been locked, but was unsure of how they could lock that style of refrigerator.	S 630	A lock was applied to the medication refrigerator door on 10-16-25 to ensure that the medication is only accessible to staff members that are authorized to administer the medications. Administrator or designee will educate staff authorized to administer medications on the " Storage of Medications" policy to ensure understanding and compliance by 11-17-25. Acknowledgement of education received will be stored in the employee personnel records. Administrator or designee will audit the medication refrigerator to ensure it is properly locked 3 times per week for 2 weeks, 2 times per week for 2 weeks, and 1 time a week for 2 weeks. An entry on the caregiver task list on the EHR has been added to each shift to ensure that the medication refrigerator has been locked. Audits to occur at random times across all shifts. Data will be brought to the QA committee for recommendations on continuing or discounting the audits.	11/17/25

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S 630	Continued From page 18 3. Review of the provider's 2/1/25 Storage of Medications policy revealed that "the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." *" ...B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) [are] permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access."	S 630		
S 670	44:70:07:07 Medication Administration A registered nurse shall provide medication administration training pursuant to § 20:48:04.01 to any unlicensed assistive personnel employed by the facility who will be administering medications. Unlicensed assistive personnel shall receive initial and ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on registration verification review, employee file review, interview, and policy review, the provider failed to ensure one of three medication aides reviewed (caretech B) was registered as an unlicensed medication aide with the South Dakota Board of Nursing (SD BON) prior to permitting them to administer resident medications.	S 670	Care tech B has taken and passed the SDBON testing to become registered as a UMA with the State of South Dakota as of 10-29-25. Administrator of designee will audit all medication aide employees to ensure they have completed the initial and or annual medication aide training, and the SD BON website to ensure all medication aides are currently registered as an UMA by 11-15-25	11/15/25

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S 670	Continued From page 19 Findings include: 1. Review of the SD BON registration verification website revealed that caretech B was not registered as an unlicensed medication aide (UMA). 2. Review of caretech B's employee file revealed she had completed the online training to be a UMA on 5/9/25 and an unlicensed diabetes aide (a person who has the training to inject insulin for someone else) (UDA) on 5/10/25. 3. Observation and interview on 10/8/25 at 8:29 a.m. with caretech B revealed she was administering medications to residents in the dining room. She confirmed that she administered a resident's insulin injections, but that resident was in the hospital. 4. Interview on 10/8/25 at 9:59 a.m. with administrator A revealed that she performed the skills checks to ensure caretech B was competent to administer medications and insulin injections. She was not aware that caretech B was required to register as UMA with the SD BON. 5. Review of the provider's undated "Dakota Sun Training Program Requirements (Medication Aide Training Program = MATP)" policy revealed: *" ...After completing the approved MATP ... the individual may apply to be registered as a Medication Aide with the SD Board of Nursing. * ...The medication aide may administer medications only as delegated by a licensed nurse, and under supervision. *The tasks must be within what is allowed by South Dakota's Nurse Practice Act and rules	S 670		

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S 670	Continued From page 20 governing unlicensed assistive personnel (UAP)."	S 670		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) who self-administered medications was assessed for the ability to safely self-administer that medication. Findings include: 1. Interview on 10/7/25 at 3:18 p.m. with resident 1 revealed that she kept one of her medications in her room. She kept her eye drops in her bathroom. She did not remember what the eye	S 685	QA committee consisting of the Administrator assistant administrator and one designated employee will review the "Self-Administration Medication by Residents" policy and revise as needed. The policy will include guidelines for resident medication self- administration assessments upon admission and at least quarterly A reminder will be set up to remind the administrator or RN of the need to complete the assessment every quarter after resident admission. Additional assessments to be completed upon change of care. This reminder will also appear for the assistant administrator to see, to ensure that the administrator has completed the assessment as stated. The assistant administrator or designee will audit all files of residents who self-administer medications on a quarterly basis for 2 consecutive quarters to ensure the assessments are completed and assess whether the reminders are working as planned.	11/23/25

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S 685	Continued From page 21 drops were called, but she said she would take them for her "eye pressure." She grabbed the eye drops from her bathroom and confirmed that the eye drops were "Latanoprost sol [solution] 0.005%." She would place one drop into each eye before she went to bed. She said that staff asked her each day if she administered the eye drops when they brought the rest of her nighttime medications to her. 2. Review of resident 1's electronic care record revealed that she was admitted on 5/15/25. She had a 5/15/25 physician's order for "Latanoprost Sol 0.005%," in "both eyes" daily at 8:00 p.m. Instructions for that order included "[Resident 1] will do her own eye drops and she has a bottle in her bathroom. ...Please ask and/or remind her at bedtime to make sure that she is using them ..." There was no documentation that she was assessed for her ability to safely self-administer medications. 3. Interview on 10/9/25 at 10:42 a.m. with administrator A revealed that when resident 1 admitted to the facility, she completed resident 1's medication self-administration assessment, but she did not document those results anywhere. She completed and documented a medication self-administration assessment for resident 1 on 10/8/25 in the resident's electronic care record. She was not aware that the medication self-administration assessments were to be completed quarterly. 4. Review of the provider's undated Self-Administration of Medication by Resident's Policy revealed: *"POLICY STATEMENT: Self-administration of medications by residents [is] not encouraged.	S 685		

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S 685	Continued From page 22 When medications are to be self-administered the following are required: -A. An assessment will be done by RN [registered nurse] to assure that [the] resident is competent for self-administration prior to the physician or authorized prescriber ordering the medication. -B. A written medication order must be obtained from the physician or authorized prescriber for specific medications to be self-administered. The order must include the medication, dose, frequency, route, indication and whether the medication is to be stored at bedside. -C. The Medication Administration Record (MAR) should indicate that the medication will be kept at 'Bedside Medication' if the medication is to be self-administered and kept in the resident's room. -D. The nursing personnel responsible for medication administration shall record each self-administered dose by the resident of the [MAR]. -E. The RN will do a re-assessment of the resident's ability to continue to self-administer every quarter or as needed if changes in [the] resident's medical or cognitive ability are noted by staff."	S 685		