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
	11034	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND SENIOR LIVING-RUSHMORE, LLC	413 E FAIRLANE DRIVE RAPID CITY, SD 57701

(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 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 12/2/24 through 12/4/24. Areas surveyed included: resident abuse and resident neglect. Heartland Senior Living-Rushmore, LLC was found not in compliance with the following requirements: S030, S120, S275, S450, S838 and S846.	S 000		12/16/24
S 030	44:70:01:07 Reports To The Department Each facility shall report 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 other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for 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	S 030	1. All residents in facility are affected by reporting processes. Investigators asked we keep it quiet and spoke to staff individually versus a group due to the nature of close POA and suspected individual. 2.) DOH Reporting Incidents and Incident Form have been updated. Updated policy to include all such manners are documented and assessed per new policy to report to DOH, when questionable, will report. Staff are to notify RN or Administrator when they have completed an incident form, so it can be attended to. All incident reports must now be signed off by Administrator or RN after reported/reviewed. 3.) All incident reports will be reviewed and compared with new Reporting Policy, Administrator or RN will complete all ongoing monitoring, and reporting. This will be ongoing monitoring daily as needed. Education will be provided on new hire and every month for 3 months to assure staff are all understanding the new process of incident reports.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jesika Floyd — TITLE: Administrator — (X6) DATE: 12/26/24

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S 030	Continued From page 1 reported event. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, adult protection services (APS) report review, interview, and policy review, the provider failed to investigate and report to the South Dakota Department of Health (SD DOH) one of one sampled resident (2) whose family member was observed inappropriately touching her. Findings include: 1. Review of the 10/14/24 APS report revealed: *On 10/13/24 an unidentified caregiver entered resident 2's room during evening rounds and witnessed the resident's power-of-attorney's (POA) spouse "rubbing the resident in her private area between her legs and on her buttock area." -The POA's spouse stated he was "changing her [the resident]." He "appeared to be nervous and left a short time later." *Former administrator B was notified of the incident on 10/14/24. -APS and the local police department were notified of the incident on 10/14/24 but the SD DOH was not notified of the incident. Observation and interview on 12/2/24 at 2:30 p.m. with activities director E revealed: *Resident 2 was not in her room because her POA had taken her out of the facility. *Activities director E was aware of the 10/13/24 incident above. -Only the POA and not the POA's spouse had visited the resident inside of the facility since that incident. *Activities director E felt the resident "loves him"(the POA's spouse) and the resident was not apprehensive when he had visited in the past.	S 030	CA: Each incident will be assessed immediately for potential abuse/neglect and evaluated of reporting. Anything reported to investigators or law enforcement will be reported to DOH	

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S 030	Continued From page 2 -She had observed the POA's spouse giving resident 2 long, "odd" hugs in the past. *She thought the 10/13/24 incident was investigated by former administrator B. -Caregivers had not been given any specific guidance regarding how to respond if the POA's spouse had returned to visit resident 2 after 10/13/24. Review of resident 2's electronic medical record revealed: *Her admission date was 6/11/24. -Her POA and the POA's spouse had cared for the resident in their home before the resident was admitted to the assisted living center. *The resident's primary diagnosis was Alzheimer's dementia. Her 8/7/24 Brief Interview for Mental Status (BIMS) assessment score was "4" which indicated she had severe cognitive impairment. *Interdisciplinary progress note documentation for 10/13/24 revealed no mention of the incident involving the resident and the POA's spouse. A behavioral note on that same date at 8:08 p.m. indicated, "She [resident 2] had a good evening." Interview on 12/3/24 at 10:15 a.m. with interim administrator/co-owner A regarding resident 2 revealed: *Since 10/13/24, the POA's spouse has been restricted from visiting resident 2 inside the facility. -Former administrator B had discussed that visitor restriction in an All Staff Meeting that occurred after 10/13/24. -Interim administrator/co-owner A had not attended that meeting to have known how this information was presented to the staff. *There was no documentation to support the visitor restriction had been discussed between	S 030		

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S 030	Continued From page 3 the facility and the POA. *There was no documented facility investigation or action plan in response to the 10/13/24 incident. -Former administrator B was responsible for having reported the incident to the SD DOH but that had not occurred. Interview on 12/4/24 at 7:40 a.m. with business office manager C revealed: *She and/or a nurse coordinated the monthly All Staff meetings. -Former administrator B had not attended an All Staff Meeting for "at least the past eight months" before she was terminated. Review of the provider's 8/28/24 Reporting to the Department of Health policy revealed: *The administrator or a registered nurse (RN) was responsible for notifying the SD DOH of any report of resident abuse. *"2. Administrator or RN will investigate the situation and turn results of findings to the Department of Health using the Event reporting and answer any follow up questions they may have regarding the incident."	S 030		
S 120	44:70:02:08 Linen The supply of bed linens must equal two times the licensed capacity of the facility. The facility shall develop and implement written procedures for the storage and handling of soiled and clean linens. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy	S 120	1.) All residents would potentially be affected by this should they not have an extra set of linens. 2.) Each building census was assessed and linens consisting of fitted sheets, flat sheets, blankets, washcloths, hand towels, and towels were ordered to secure compliance in having enough extra linens. Laundry rooms were labeled for each item	12/19/24

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S 120	Continued From page 4 review, the provider failed to ensure sufficient quantities of linen had been available for use by all sixteen residents who resided in that building. Findings include: 1. Observation on 12/2/24 at 2:15 p.m. revealed inside the locked linen room were cleaning supplies, adult incontinent supplies, and gloves. Observation and interview on 12/2/24 at 2:20 p.m. with unlicensed medication aide J of the laundry room revealed: *Linen was stored in the cupboards and cabinets in that room. -There were ten wash cloths or hand towels, and eight bath towels stored in those cupboards and cabinets. -There were no blankets, comforters, or bedding. *She stated she would have had to borrow linen from another one of the on-site residences if there was an emergent need for linen. Interview on 12/4/24 at 10:15 a.m. with interim administrator/co-owner A revealed she was not aware of the regulation that required the facility to have maintained an adequate supply of linen for residents' use. A Linen policy was requested from administrator/co-owner A on 12/3/24 at 4:15 p.m. On 12/4/24 at 10:30 a.m. a 5/1/24 Housekeeping and Maintenance policy was provided. That policy made no mention of maintaining a sufficient supply of linen for residents' use.	S 120	where it is to be stored. Housekeeping will complete a weekly walk through monitoring for any decreased numbers or lost items of any supply that wouldn't meet the number requirement. Any needs that come up, Housekeeping will report to Administrator to order. Housekeeping and Linen Storage policy to include regulation of excess linen.	
S 275	44:70:04:01 Governing Board Each facility operated by a limited liability partnership, a corporation, or a political	S 275		1/18/25

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S 275	Continued From page 5 subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this chapter pertaining to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the governing body failed to ensure the facility was administered in a manner that ensured the daily overall management, resident care, and resident safety was in compliance with the Administrative Rules of South Dakota 44:70 Assisted Living Center regulations. Areas included: *Investigation and notification to the South Dakota Department of Health of reportable incidents. *Ensuring sufficient quantities of linen were available for resident use. *Storing food in a safe and sanitary environment. *Managing challenging behaviors demonstrated by cognitively impaired residents to mitigate their risk for abuse and neglect. *The process and expectations for grievance documentation, investigation, and follow-up. Findings include: 1. Interviews on 12/2/24 at 3:00 p.m. and again on 12/4/24 at 10:30 a.m. with interim administrator/co-owner A revealed: *She had assumed co-ownership of the facility in July 2024 and had been responsible for the oversight and supervision of former administrator B. -Former administrator B was often not available to speak or meet to discuss staffing or resident	S 275	1.) All residents and staff are affected by governing body and policy. 2.) Governing policy was structured to provide guidance of responsibilities of Governing body and who to report to. 3.) A member of the Governing body will review and sign off on all quarterly QAPI meetings and address all concerns needed within 48 hours of meeting.	

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S 275	Continued From page 6 care. *Concerns regarding former administrator B were identified on 9/18/24 two days after interim administrator/co-owner A terminated the director of nursing (DON) for issues related to resident assessments and the monthly medication recommendations made by the pharmacy consultant. -Former administrator B had been responsible for the supervision and oversight of that DON. *Complaints brought forward to former administrator B by a local adult day care (ADC) on 10/16/24 had not been shared with interim administrator/co-owner A. -She was first made aware of resident care concerns after a face-to-face meeting with a local advocacy agency on 11/14/24. They had previously reported to former administrator B resident care concerns similar to those shared by the ADC. Former administrator B had not reported those concerns to interim administrator/co-owner A. *On 11/18/24 former administrator B was terminated. A Governing Body policy was requested of interim administrator/co-owner A on 12/4/24 at 10:45 a.m. however the facility had no such policy. Refer to S030, S120, S450, S838 and S846.	S 275		
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06.	S 450	1..) All residents are affected. 2.) A meeting with dietary manager was completed, and a food storage policy was created in coordination with food safety guidelines and regulation of Administrative Rule of South Dakota.	12/30/24

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S 450	Continued From page 7 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain a safe and sanitary food service environment related to food storage in one of one kitchen refrigerator. Findings include: 1. Observation on 12/2/24 at 1:30 p.m. inside of the kitchen refrigerator revealed the following: -Undated and unlabeled single-use plastic containers of what looked like corn, cooked sausage, pickles, and green beans. -A plastic wrap-covered bowl dated "10/21" and labeled "Tarter sauce." It was not known if the tartar sauce was home-made or processed. -Undated plastic bags of shredded cheddar cheese, sliced white cheese, a home-made bread loaf, and hard-boiled eggs. -Undated and unlabeled plastic squeeze bottles that had been filled with relish, barbeque sauce, salad dressings, and mustard. None of those bottles had caps that covered their openings. Observation of the contents of the kitchen refrigerator and interview on 12/3/24 at 8:00 a.m. with dietary manager (DM) D revealed: *Overnight staff had been responsible for inspecting the contents of the refrigerator each night to ensure all food items had been appropriately labeled, dated, or removed from the refrigerator. -The food items above had not been appropriately labeled, dated, or removed from the refrigerator by the overnight staff as she had expected. A Food Storage Policy was requested on 12/3/24 at 4:15 p.m. from interim administrator/co-owner	S 450	3. The Dietary Manager will now follow a daily template created, auditing all stored food in refrigerators and freezers, watching for expired dates, labeling, and container usage. Dietary Manager will hold monthly meetings to re-educate any findings she may need to review with team. Refridgerators have all been cleaned out with proper dates, containers, and exp. dates noted on all items in refrigerator and freezer.	

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S 450	Continued From page 8 A. A 5/1/24 Food Service and Menu Planning policy was provided that made no reference to food storage expectations.	S 450		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on e-mail communication review, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) was free from neglect. Findings include: 1. Review on 12/4/24 at 3:00 p.m. of a 12/4/24 e-mail communication with interim administrator/co-owner A from the local adult day care (ADC) that resident 1 attended revealed: *When the ADC staff had changed resident 1's pull-up brief earlier that day he was wearing the same pull-up brief he had worn to the ADC on 12/3/24. *Photographs attached to that e-mail included: -One photo that showed the lower half of resident 1's body sitting on a toilet wearing a pull-up brief dated "12/3" and initialed "ADC". --There was visible redness on the inner aspects of each of his upper thighs near his groin.	S 838	1.) All residents are affected by the quality of life the facility provides. 2.) Residents with cognitive impairment are affected. All residents BIMS score will be collected. Those that fall under severe cognitive impairment will be on 2 hour hygiene and incontinence checks to be changed and documented on. 3.) Any refusals of changes will be reported to nurse. POC charting will be monitored weekly on cognitively impaired residents to see what staff are not documenting care on residents. Education provided to staff on importance of asking for assistance and reporting to nurse for assistance to change briefs and any other hygiene/safety related care. Specific education provided of resident's daily outing/activity and he must be toileted and changed prior to leaving the facility. Education provided that Every resident should be toileted and changed every morning upon awaking, and toileted and hygiene checks every 2 hours after.	1/18/24

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S 838	Continued From page 9 -The second photo showed the yellowed-color inside of the brief's crotch after it was removed from the resident. -The third photo showed that brief held up by the waist band. --The crotch of the brief sagged with the amount of contents held inside of it. Continued interview with interim administrator/co-owner A and review of resident 1's electronic medical record revealed: *Resident 1's 8/7/24 Brief Interview for Mental Status assessment score was "3" which indicated he had severe cognitive impairment. *His primary diagnosis was Alzheimer's disease. He was continent of his bowel but incontinent of urine and wore a pull-up brief *Resident 1's 3/1/24 care plan indicated: -He was continent of bowel and bladder but that was incorrect. -Resistive to care but there were no interventions for staff to follow when that occurred. *Caregivers had documented every 2-hour visual checks of resident 1. At the time of those checks, caregivers had been expected to give the resident verbal cues and assistance to help him use the toilet and/or change his pull-up brief. It was a "hit or miss" if that had consistently occurred. Interview on 12/4/24 at 3:10 p.m. with interim administrator/co-owner A and unlicensed medication aide (UMA) G revealed: *UMA G had worked on 12/3/24 from 6:00 p.m. to 10:00 p.m. but had not provided resident 1 any toileting assistance during that time. -The caregiver who worked with her had reported no toileting concerns with resident 1 during that time. --That caregiver failed to respond to a text	S 838	Care plans and assessments have been getting re-assessed from previous deferred assessing accurately. Resident BIMS were not completed prior to current ownership, this has been done to start reviewing which residents would be at risk of not being able to voice when incontinent or when to toilet. Those that fall within BIMS range set by nursing and policy will have updated task and daily plan of care tasks to include mandatory reminders to staff to toilet.	1/18/25

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S 838	Continued From page 10 message sent to her from interim administrator/co-owner A requesting her to call her back. Interview on 12/4/24 at 3:15 p.m. with interim administrator/co-owner A and caregiver K regarding the above incident revealed: *Resident 1 was dressed and had eaten breakfast when caregiver K had arrived to work that day. -At 7:00 a.m. she tried to get resident 1 to allow her to change his pull-up brief. He was initially cooperative with her request but then refused her help. *UMA J attempted to change resident 1's pull-up brief at 7:30 a.m. that morning but was not successful either. -Neither UMA J or caregiver K had contacted any other staff for assistance with resident 1. *Some time between 8:30 a.m. and 9:30 a.m. that same day the ADC staff arrived to transport resident 1 to ADC. -UMA J notified ADC staff resident 1's pull-up brief was not changed that morning. Continued interview with interim administrator/co-owner A revealed: *Resident 1's dated and initialed pull-up brief would have been placed on him by the ADC staff sometime before 3:00 p.m. on 12/3/24. -He would have worn that brief no less than 18 hours by the time he left the facility on the morning of 12/4/24 for the ADC. *It was unknown how many times resident 1 had voided inside of that same pull-up brief during that time. She agreed that was neglect. *Resident 1's care should not have been handed off to the ADC staff without first having ensured his pull-up brief was changed. -If staff were unable to provide resident 1	S 838		

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S 838	Continued From page 11 continency care due to his resistance she would have expected them to contact her or other caregiver for assistance. *Interim administrator/co-owner A stated staff training related to managing cognitively impaired residents with behavioral concerns was inadequate and ineffective. Review of the provider's 5/1/24 Vulnerable Adult Maltreatment-Prevention and Reporting policy revealed: "1. During orientation, all staff at Heartland Senior Living, LLC will be trained in the identification of incidents of maltreatment including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. "	S 838		
S 846	44:70:09:10(1-4) Grievances The grievance process must include the facility's efforts to resolve the grievance and documentation of: (1) The grievance; (2) The names of the persons involved; (3) The disposition of the matter; and (4) The date of disposition. This Administrative Rule of South Dakota is not met as evidenced by: Based on a review of a South Dakota Department of Health complaint intake, interview, and policy review, the provider failed to ensure a resident's representative's grievance had been documented and followed up on for one of one resident (6). Findings included: 1. Review of the November 2024 grievance form	S 846	1.) All residents are affected by grievances. Policy has been updated on specifics to include, and form has been re-created. 2.) This policy and form has been educated to staff and updated in communication binders. 3.) Administrator or RN will address each one, but administrator will always sign off. They will be monitored monthly and kept in one area. Grievances will be brought to quarterly QAPI meetings, addressing reportables and monitoring for trends and/or improvements facility can make.	12/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11034	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND SENIOR LIVING-RUSHMORE, LLC	413 E FAIRLANE DRIVE RAPID CITY, SD 57701

(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 846	Continued From page 12 revealed: *Resident 6 was missing pairs of jeans, a belt, and a blanket. *There had been an unannounced person coming into his room, who was not a staff member. *There was no facility response to the grievance on the form. Review of resident 6's electronic medical record revealed: *His admission date was 3/11/24. *His discharge date was 11/26/24. *His diagnoses were dementia, headaches, insomnia, hypertension, and major depressive disorder. *His mini-mental score was 20, which indicated he had mild cognitive impairment or early dementia. Interview on 12/4/24 at 10:45 a.m. with interim administrator/co-owner A revealed: *She was unaware of any grievances until the morning of 12/2/24 when she was retrieving the grievance book, to give to the surveyors, and it was empty. The administrator assistant (AA)/unlicensed medication aide (UMA) I told her she had three grievance forms in her backpack. *AA/UMA I had told her she found them in the shred bin the day after the last administrator was terminated. Interview on 12/4/24 at 11:05 a.m. with AA/UMA I revealed she: *Stated she found the grievance form on 11/11/24 in a pile of documents and saw that there had been no response from the facility. *Was the medication aide on duty, and decided to look for the missing personal property in the residents' rooms that had the same scheduled shower and laundry day as resident 6.	S 846		

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S 846	Continued From page 13 *Did not find his personal property in the above residents' rooms, and started to look in the rest of the residents' rooms to try and find resident 6's missing personal property. *Did not find the missing personal property in any of the residents' rooms. *Had not documented she had looked for the missing personal property or had called the resident's representative who had filled out the grievance form. *Stated she had thought the bottom portion of the grievance form was to be filled out by the administrator and signed by the administrator. She had not notified the administrator of the grievance form or what she had done to find the missing personal property. *Stated she found that grievance form again in the shred bin on 11/19/24, the day after the last administrator was terminated. *Stated she gave the grievance form to the interim administrator/co-owner A last week. Continued interview on 12/4/24 at 11:42 a.m. with interim administrator/co-owner A revealed she again stated she had not received the grievance forms until 12/2/24 when she was retrieving the grievance book for the surveyors and AA/UMA I stated she had three grievance forms in her backpack. Review of the provider's revised 5/1/24 Grievance policy revealed: "Policy: To ensure complaints regarding Heartland Senior Living, LLC are resolved in a timely and appropriate manner for employees or residents that have concerns or complaints." -"Procedure: Complaints that cannot be easily resolved or have not been resolved to an employee or resident's satisfaction should be dealt with in the following way:"	S 846	Educated provided to staff that progress notes need to be completed Notified staff of where all grievances are to be turned in, the new form to be completed, and cleaned out policies and forms, to include the new ones only. Reviewed with staff by shift the importance of following new grievance and what/when to complete one. Grievances will be reviewed by administrator with quarterly QAPI meetings, and reviewing those that were reportable grievances Staff member given training on HIPPA and having patient information in work bag leaving work premises. Staff was not at work the week before to have turned stated grievances to administrator.	

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S 846	Continued From page 14 "1. A community complaint form should be filled out by the resident, resident representative, or employee and given to the supervisor of the department or to the Assisted Living Administrator." "5. During the investigation process, and when possible, residents, resident representatives, or employees will be asked to participate in determining the solution and bring about resolution of the complaint." "9. Finalized resident complaints will be kept in the resident record."	S 846		