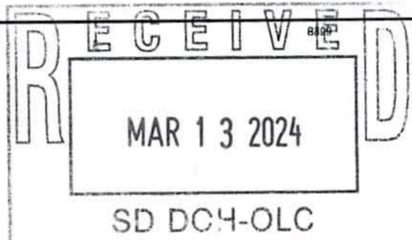
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46723	A. BUILDING: ______ B. WING ______	C 01/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 1/30/24 through 1/31/24. Edgewood Greenleaf Flandreau LLC was found not in compliance with the following requirements: S131, S200, S305, and S405. 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 1/30/24 through 1/31/24. The areas surveyed were transfer and discharge practices. Edgewood Greenleaf Flandreau LLC was found in compliance.	S 000		
S 131	44:70:02:09 Infection Prevention And Control The facility shall have written procedures that govern the use of aseptic techniques and procedures in all areas of the facility. Each facility shall develop written policies and procedures for the handling and storage of potentially hazardous substances. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, observation, manufacturer's label review, and job description review, the provider failed to ensure effective infection control processes had been implemented related to the following areas: *There were no written policies or procedures for housekeeping staff to follow for environmental cleaning and disinfection processes in the facility. *One of one observed housekeeping supervisor	S 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alison Johnson
TITLE: Executive Director
(X6) DATE: 03/13/2024



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S 131	Continued From page 1 (D) had not: -Followed manufacturer's directions to disinfect one of one resident 3's bathroom. -Used an appropriate disinfectant product to clean and disinfect resident 3 bathroom's floor. Findings include: 1. Interview on 1/31/24 at 9:20 a.m. with housekeeping supervisor D in the hallway revealed: *She worked part-time and had been employed for two and a half years. *Her duties included cleaning the common areas of the facility and the resident apartments on a weekly basis. Observation and interview on 1/31/24 at 9:35 a.m. of housekeeping supervisor D cleaning resident 3's apartment bathroom revealed she: *Put on a pair of disposable gloves and used a "Bathroom Cleaner and Disinfectant" which she sprayed on the surfaces of the toilet seat, rim, tank, and base. -Immediately wiped those surfaces with a dry cloth. *Removed the resident's personal products from half of the sink counter and used a "Multi Surface Cleaner and Disinfectant" which she sprayed on the sink, faucet, and counter. -Immediately wiped those surfaces with a dry cloth. *Moved the resident's personal products to the cleaned side of the sink counter and sprayed the cleaner/disinfectant on the other half of the sink. -Immediately wiped those surfaces. *Removed the resident's personal products from the shower and used the "Multi Surface Cleaner and Disinfectant" which she sprayed on an area and wiped it immediately before moving to another area wiping that area immediately after	S 131	ED contacted corporate purchasing director in which she explained that Ecolab peroxide multi surface cleaner & disinfectant would be transitioning to Ecolab rapid multi surface disinfectant cleaner. Housekeeping supervisor informed of the transition as well as the 3-minute contact time. Facility to use up current supply of peroxide multi surface cleaner and then transition to rapid multi surface disinfectant. Rapid multi surface disinfectant already on hand at community. Ecolab representative came to facility and modified current dispenser to align with rapid multi surface disinfectant. ED met with housekeeping supervisor and explained why we can't use outside chemicals, housekeeping supervisor agreed to take this product out of the facility and utilize facility approved products. ED obtained Edgewood Procedure Guide from corporate purchasing director and will modify to our community as well as add contact times where appropriate. ED also advised housekeeping supervisor that we would not need to utilize end-bac, areosol disinfectant, due to already utilizing rapid multi surface disinfectant cleaner. ED, CSD, and Housekeeping supervisor attended virtual housekeeping training opportunity with Ecolab. Regional Vice President visited community.	

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S 131	Continued From page 2 spraying. *Swept and then mopped the bathroom floor with a commercial product that she had brought into the facility that only cleaned and deodorized, stating she used it as the residents "loved" the product's lemon scent. Review of the "Bathroom Cleaner and Disinfectant" manufacturer's label and instructions revealed: *"One-step daily cleaning and disinfection spray application:" -"Spray 6-8 inches from the surface." -"Allow surface to remain visibly wet for a 5 minute contact time and then remove solution with a clean wet mop, cloth, sponge, ..." Review of the provider's "Multi Surface Cleaner and Disinfectant" manufacturer's instructions and label revealed: *"For use as a Multi-Surface Cleaner/Disinfectant:" -"Spray 6-8 inches from the surface; making sure to wet surfaces thoroughly." -"All surfaces must remain wet for the required time indicated in the directions for use [three to five minute contact times]." -"Wipe surfaces or allow to air dry." Review of the commercial product housekeeping supervisor D had brought in to use on the floors revealed: *The label stated "Multi-Surface Cleaner". *The directions for use were for "General Cleaning and Deodorizing." *There was no mention of that cleaning product killing germs or that it was a disinfectant. Interview on 1/31/24 at 10:15 a.m. with housekeeping supervisor D regarding her	S 131	RVP examined communities housekeeping chemical closet and directed ED on what chemicals to utilize and what chemicals to dispose of. Housekeeping supervisor is currently adhering to all contact times with facility approved chemicals. Starting in the restrooms and cleaning in bedrooms during contact time. Ecolab Lemon-Eze utilized for toilet bowl cleaner. Peroxide multi surface cleaner & disinfectant currently being utilized with 5 minute contact time until product runs out. Facility will then utilize rapid multi surface disinfectant cleaner with a contact time of 3 minutes. ED will provide appropriate training to prevent future noncompliance in upcoming staff meeting as well as provide updated Edgewood Procedure Guide to current and new employees. We will also provide a copy of this guide in our housekeeping closet for review. Housekeeping supervisor will continue to monitor appropriate contact times daily indefinately. 1. We only staff one housekeeper. We plan to educate all other staff of new products being utilized, products that we will no longer utilize, as well as updated training at our staff meeting.	03/15/2024

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S 131	Continued From page 3 cleaning process and the above product contact times revealed: *She stated the process she used for resident 3's bathroom was the process used to clean all the residents apartments' bathroom. *She was unaware of the contact times required for disinfection. *She confirmed she had not followed the manufacturer's instructions. *She stated "I've been doing it wrong all these years." Interview on 1/31/24 at 10:50 a.m. with executive director A regarding housekeeping policies and procedures revealed she was not aware of any housekeeping policies and procedures Interview on 1/31/24 at 1:00 p.m. with executive director A regarding the above observations and products revealed: *She agreed that the provider's products for cleaning and disinfection had not been used as directed by the manufacturer regarding the required contact times for disinfection. *The directions found on the product labels for cleaning and disinfection should have been followed. *She was aware housekeeping supervisor D used commercial products that she had brought into the facility. -She was not aware that the commercial product housekeeping supervisor D used on the residents' bathroom floors had no disinfection properties. *She stated that housekeeping should be using only the provider's products. Review of the provider's May 2021 "Housekeeping Supervisor" job description revealed:	S 131	ED will audit/monitor housekeeping supervisor weekly for one month to ensure appropriate contact times and chemicals are being utilized. If appropriate contact times and chemicals are being utilized, ED will then monitor housekeeping supervisor monthly indefinitely and keep appropriate audits in a binder. ED will also monitor the housekeeping closet weekly for one month to ensure appropriate facility-approved chemicals are being utilized and no outside chemicals are on hand at the community. If appropriate chemicals are being utilized, ED will monitor housekeeping closet monthly indefinitely. ED, CSD, Dining Supervisor, Maintenance Tech, and Housekeeping Supervisor will meet the first Thursday of every month to review audits that ED has completed and look for areas of improvement if need be.	

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S 131	Continued From page 4 *"Duties and Responsibilities" included: -"Insure [sic] Infection Control measures are followed at all times." -"Cleaning duties to be performed within areas of responsibility include but are not limited to ... vacuum carpet, clean floors, sanitize and disinfect bathroom areas, etc."	S 131		
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, and interview, the provider failed to maintain compliance with fire safety requirements required by the Life Safety Code, NFPA 101 (kitchen extinguisher signage, smoke door and fire door gaps, fire door latching, electrical panel registry, and generator maintenance logs). Findings include: 1. Observation on 1/30/24 at 9:40 a.m. revealed the required signage for the K-type fire extinguisher in the kitchen was not in place. Interview with maintenance technician C on 1/30/24 at 9:45 a.m. revealed the procedure	S 200	1. ED called out to C & R Suppression and informed company that we need appropriate signage above our K fire entinguisher in our back pantry. C & R hung correct signage above K fire entinguisher	03/15/2024

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S 200	Continued From page 5 explained on the required signage would not have been followed and risk to staff would have resulted if there were a fire. 2. Observation on 1/30/24 at 10:00 a.m. revealed a one-half-inch gap between the cross-corridor doors leading to the east wing. Further tour found the same gap evident at all cross-corridor smoke or fire doors. The required maximum gap of one-eighth inch was exceeded in all cases. Interview with maintenance technician C at the time of the observations acknowledged the gap would allow smoke to pass through the opening. 3. Observation on 1/30/24 at 10:15 a.m. revealed the south cross-corridor fire door leading to the west wing did not latch at the top latch. Further trials of the door revealed a probable cause of abrasion on the top of the door. Further inspection of the door revealed the 90-minute door was only supplied with one latch point rather than the two required latches. Maintenance technician C was present and acknowledged the latching difficulties with the door at the time of the observation. 4. Observation on 1/30/24 at 11:00 a.m. revealed the west mechanical room, which housed the furnace and the building's hot water heater, included an electrical panel which did not have a panel schedule (registry) for the breakers. Interview with maintenance technician C at the time of the observation revealed he was not aware there was no schedule, and he did not know what was served by individual breakers. 5. Record review on 1/30/24 at 12:05 p.m. revealed excellent documentation of weekly generator inspections, but no documentation of the monthly automated generator load tests or of	S 200	2. Maintenance Technician installed self adhesive door brush strips to fire doors and both sets of smoke doors. 3. Regional Maintenance Director assisted our maintenance technician to adjust the fire door hinge that was causing an issue/abrasion resulting in the door to not properly latch. 3. Regional Maintenance Director and Maintenance technician will install fire pin. 4. Maintenance Technician labeled all breakers and outlets.	

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S 200	Continued From page 6 the battery testing. Those requirements were referenced in NFPA 110, Standard for Emergency and Standby Power Systems through the Life Safety Code, NFPA 101. Interview with executive director A during the exit interview on 1/30/24 at 3:15 p.m. acknowledged that data was missing, and revealed the batteries were probably not being tested.	S 200	5. Regional Maintenance Director added monthly loaded tests on TELS, facilities maintenance website being utilized. ED called out to Cummins to inform them that we would need an individual to come to our facility and demonstrate how to perform a montly loaded test. Cummins scheduled to arrive to demonstrate loaded test. Regional Maintenance Director added monthly battery testing to TELS platform, facilities maintenance website currently being utilized.	
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel record review, interview, and health history screening form review, the provider failed to ensure five of five sampled employees (E, F, G, H, and I) were evaluated by a licensed health professional within 14 days of hire. Findings include: 1. Review of the employee's personnel records revealed the following: *Employee E was hired on 10/16/23. *Employee F was hired on 8/16/23. *Employee G was hired on 9/11/23. *Employee H was hired on 9/8/23. *Employee I was hired on 12/11/23. *The above employees: -Had no health history screening forms completed.	S 305		

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S 305	Continued From page 7 -Were not evaluated by a licensed health professional. Interview on 1/31/24 at 2:15 p.m. with executive director A and clinical services director B regarding employee health evaluations revealed: *They were both unaware that: -New employees needed health evaluations completed. -A licensed health professional needed to review, sign, and date an employee health evaluation. *The provider's corporation had "recently revamped and updated the orientation process and forms." *They agreed that employee health evaluations had not been completed. Interview on 1/31/24 at 4:30 p.m. with executive director A after she had communicated with the provider's regional vice president regarding the policy on employee health evaluations revealed: *There was no policy on employee health evaluations. *She provided: -The provider's four-page September 2023 "New Hire Process Checklist" which included the "Health History Screening Form". *When reviewing the provider's November 2013 "Health History Screening" form she stated she: -Was not aware of that form. -Had been informed that the statement at the top of that form was included to cover the policy. *She confirmed the health screening requirement was not met. Review of the provider's September 2023 New Hire Process Checklist revealed: *"Health History Screening Form" was listed on page 3 of 4. *Instructions stated "This is located on	S 305	ED will audit/monitor that CSD completes Health screening evaluation within 14 days of hire every two weeks for two months. ED will then monitor that CSD completes Health Screening Evalution within 14 days of hire monthly indefinately. During monthly quality assurance meetings, these audits will be reviewed and will be adjusted appropriately if need be. S 305 In compliance with regulatory requirements, the facility has implemented a comprehensive personnel health program to safeguard the well-being of our residents. This program mandates that all personnel undergo evaluation by a licensed health professional for reportable communicable diseases, which could pose a threat to others, either prior to assignment to duties or within fourteen days after employment.	03/15/2024

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S 305	Continued From page 8 SharePoint to be printed and completed." Review of the provider's November 2013 "Health History Screening" form revealed: *This form was "For Newly Hired Employees". *The policy statement on the top of the form "This form is to be completed as part of the essential paperwork processed on the first day of employment, before any other training or work with residents is started." *The following statements: -"I have not current symptoms or diagnosis by a healthcare practitioner of a communicable disease, ..." -"I understand that this health history screening must be completed prior to assuming job responsibilities. A physical examination may be required by [provider's name] based on the results of the health history screening." *A signature line for "Employee Signature (required)" and "Date". *A signature line for "Licensed Nurse Signature (required) and/or Manager if applicable" and "Date" *A note "*SD [South Dakota] must receive the licensed nurse signature."	S 305	Corrective action was taken for employees E,F,G,H, and I that did not have Personnel Health Program form completed. They were educated and completed the forms. To make sure all other staff were in compliance, they were educated regarding Health History Screening policy and the Personnel Health Program form was completed.	
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not	S 405		

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S 405	Continued From page 9	S 405		

met as evidenced by:
Based on interview, observation, record review, and policy review, the provider failed to develop and revise individual resident care plans to reflect the smoking needs of two of two sampled residents (2 and 4).
Findings include:

1. Interview on 1/30/24 at 8:00 a.m. with executive director (ED) A and clinical services director (CSD) B revealed the facility's current census of residents included two residents who smoked.

Review of the provider's listing of residents provided at 9:45 a.m. by CSD B revealed residents 2 and 4 were the residents who smoked.

2. Observation on 1/30/24 at 11:10 a.m. of resident 2's apartment revealed she was not in her apartment and her husband stated she was out of the facility smoking.

Observation and interview on 1/30/24 at 11:12 a.m. of the facility's front lobby revealed:
*Resident 2 was seated in a chair with her coat on and a four-wheeled walker beside her.
*After greeting the resident, resident 2 stated she had just entered the building after smoking a cigarette and was resting before going back to her apartment.

Continued interview with resident 2 in her apartment revealed:
*She had lived at the facility for two years.
*She smoked multiple times a day at any time she chose.
*She stated she had to smoke 25 feet from the building and often chose to smoke in her car in

S405
Thank you for your review and feedback regarding the smoking assessment in our safety reporting protocols. We have taken note of your observations and have enacted a plan of correction to address the identified concerns. — 03/15/2024

Residents' care plans have been updated to include a thorough smoking assessment under the safety catergory. These revisions now explicitly state the smoking status of resident and specify those who are deemed appropriate to smoke independently. Additionally, our community nurse will continually conduct quarterly assessments on residents who smoke to monitor their safety and address any concerns in their care plans. This ongoing monitoring will ensure timely adjustments to the care plans as needed and promote the well-being of our residents.

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S 405	Continued From page 10 the facility's parking lot. Review of resident 2's electronic medical record (EMR) revealed: *Her admission date was 11/12/21. *A 11/8/23 progress note stating the resident was smoking while sitting on her walker. When the resident was done smoking, she was trying to stand up when her knee gave way and she slowly went down to the ground. The resident used her pendant to call for help. The medication aide responded right away and found the resident outside and already on the ground. The medication aide called another staff person to help the resident get up and assisted her back to her apartment. -"Actions Taken" included: --"Will complete focused assessment and upgrade the plan of care as appropriate." --"Will update the plan of care with interventions to minimize falls." *On 11/29/23 an assessment of her care needs documented: -She was able to smoke safely, independently, and without intervention. -She smoked six to eight times a day in her car. -CSD B signed the assessment on 11/29/23. *A 1/17/24 progress note stating the resident fell outside at 6:42 a.m. while she was trying to sit on her walker. Review of resident 2's 11/29/23 Master Care Plan included: *A "General Safety" focus related to her "History of smoking". *There were no goals or interventions related to her current smoking needs. 3. Review of resident 4's EMR revealed: *Her admission date was 6/3/15.	S 405	The EHR has been updated to allow smoking assessments and care plan revisions as needed to address smoking safety. ED will audit/monitor the CSD updates care plans monthly for three months, ED will then audit/monitor that CSD updates care plans quartarly indefinately and as needed. CSD will audit/monitor that staff are reviewing updated care plans every two weeks for three months using a report on the EHR. CSD will then audit/monitor that staff are reviewing care plans monthly indefinately. All audits will be reviewed at the quality assurance meeting held the first Thursday of every month.	03/15/2024

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S 405	Continued From page 11 *A 10/16/23 progress note that stated ED A talked to resident 4 "in regards to her smoking out front when she knows she is supposed to go to the east end ... I [ED A] informed her that everyone needs to follow the rules and this would be her 1st warning ... informed her that she can still not go out front to smoke." *On 11/29/23 an assessment of her care needs documented: -She was able to smoke safely, independently, and without intervention. -She smoked ten to twelve times a day. -CSD B signed the assessment on 11/29/23. Review of resident 4's 11/29/23 Master Care Plan included: *A "General Safety" focus related to her "History of smoking". *There were no goals or interventions related to her current smoking needs. 4. Interview on 1/31/24 at 4:00 p.m. with CSD B regarding individualized resident care plans revealed: *The electronic assessment of resident care needs developed the master care plan for each resident. *She was not able to update the care plans with individualized goals, approaches, and/or interventions and stated she was limited by the electronic system's assessment process. *She stated the smoking assessment was not reflected on the individual's care plan. *She agreed that the care plan should address the smoking needs of residents who smoked. Interview on 1/31/24 at 4:25 p.m. with ED A revealed: *The two residents who smoked had been grandfathered in when the current "No Smoking	S 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46723	A. BUILDING: ____ B. WING ____	C 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 405	Continued From page 12	S 405		

Policy" had come into effect.
*She agreed that for the two residents who currently smoked, those smoking needs should have been addressed on their care plan.

Review of the provider's December 2023 policy on Service Planning/Care Planning and Coordination of Care revealed:
*"Adequate coordination of care should mean that all staff - notably the Executive Director in conjunction with an RN [Registered Nurse] ..., medical director or primary care physician should consider all factors contributing to a resident's condition and how they relate to one another."
*"As a basic health services tool, the Service Plan/Care Plan is used to identify resident care issues, how staff should monitor/observe for them, and interventions for each resident that staff can apply if necessary."
*"Because it is a primary health record, other documentation about a resident's care should coordinate with and through the Service Plan/Care Plan."
*"Services should be modified as needed to meet the resident's needs."

PRINTED: 03/25/2024
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46723	A. BUILDING: ______ B. WING ______	R 03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 000}	Compliance Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 3/22/24 for deficiencies cited on 1/31/24. All deficiencies have been corrected, and no new noncompliance was found. Edgewood Greenleaf Flandreau LLC is in compliance with all regulations surveyed.	{S 000}		

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