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
	41884	A. BUILDING: _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER INN	956 E 7TH ST WINNER, SD 57580

(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 8/29/23 through 8/31/23. Elder Inn was found not in compliance with the following requirements: S085, S125, S131, S156, S167, S215, S280, S296, S320, S337, S630, S632, S642, S654, S775, S790, and S845. 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 8/29/23 through 8/31/23. Areas surveyed included potential abuse, quality of life, and bed bugs. Elder Inn was found not in compliance with the following requirements: S125, S156, S167, S775, S790, and S845.	S 000		
S 085	44:70:02:03 Cleaning methods and facilities The facility shall have supplies, equipment, work areas, and complete written procedures for cleaning, sanitizing, or disinfecting all work areas, equipment, utensils, and medical devices used for residents' care. Common use equipment shall be disinfected after each use. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure processes had been implemented for the cleaning or replacement of items for respiratory devices including nebulizers, oxygen tubing, continuous positive airway pressure (CPAP) machines, and bilevel positive airway pressure (BIPAP) machines for three of three randomly reviewed	S 085	Residents 11, 12, and 15's respiratory equipment has been cleaned and/or the set up changed. A list of residents with nebulizers, c-pap machines, bipap machines, and oxygen has been composed for staff. The nurse will be responsible for keeping that list updated. A process to ensure cleaning of the equipment and changing of supplies for the respiratory devices has been establisted and will be monitored by the nurse. Policies for nebulizers, oxygen equpiment have been reviewed and policies for cpaps and bipaps have been created. All staff will be educated by the nurse on the updated processes for cleaning, replacement, policies, and documentation for respiratory equpment. Nurse will monitor for appropriate cleaning and replacement of respiratory equipment weekly for one month and then monthly. Audits and reporting will brought to monthly leadership meetings for review.	10/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy S. Meyer — TITLE: Administrator — (X6) DATE: 10/4/23

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S 085	Continued From page 1 residents (11, 12, and 15). Findings include: 1. Observation and interview on 8/29/23 at 1:50 p.m. with resident 15 in her room revealed she: *Utilized oxygen on a regular basis during the day. *Used her CPAP machine every night when she was sleeping. *Was unsure how often the tubing for her oxygen was replaced. *Cleaned her own CPAP mask. *Was unsure if the staff assisted with care of those respiratory devices. 2. Observation and interview on 8/29/23 at 3:40 p.m. with resident 11 in his room revealed he: *Used oxygen at all times. *Used a BIPAP machine every night when he was sleeping. *Was not sure of the process for changing the oxygen tubing or who was responsible for that. *Had not cleaned or maintained his BIPAP mask or machine and indicated it probably should have been cleaned. *Stated that the staff had not cleaned his BIPAP mask or machine either. 3. Observation and interview on 8/29/23 at 4:55 p.m. with resident 12 during his medication administration with unlicensed medication aide (UMA) D revealed: *She brought his scheduled inhaler to his room. *She indicated he already had completed his scheduled nebulizer treatment. *When asked about the process for cleaning the nebulizer mouthpiece set up the resident indicated he did that himself at the end of the day. *When asked about the process for replacing the nebulizer mouthpiece and tubing set up he indicated he was not sure when that had last	S 085		

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S 085	Continued From page 2 been replaced. *UMA D indicated there was no process for replacing the nebulizer mouthpiece and tubing. -The staff had not assisted with cleaning the nebulizer equipment as the resident completed that himself. 4. Interview on 8/30/23 at 9:30 a.m. with UMA C regarding respiratory equipment cleaning and replacement of parts revealed: *The staff had not cleaned those items on a regular basis. -Some of the residents cleaned their own devices. *There was no specified process to replace the oxygen tubing or the nebulizer setups. *She recommended asking the nurse about those items. Interview on 8/30/23 at 9:40 a.m. with registered nurse B regarding the respiratory equipment cleaning and replacement of parts revealed: *She confirmed there was no process to ensure: -The nebulizer setups or the oxygen tubing were replaced on a regular basis. -The residents' nebulizer setups or CPAP and BIPAP masks and machines were cleaned regularly. *There was no documentation to support the cleaning and replacement of those items. *She agreed respiratory devices should have been cleaned and maintained regularly for infection control purposes. Interview on 8/31/23 at 10:10 a.m. with administrator A confirmed processes had not been implemented to ensure regular cleaning and replacement of items for the residents' respiratory devices.	S 085		

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S 085	Continued From page 3 Review of the provider's 8/11/08 Oxygen Equipment Care policy revealed: *"The facility will use disposable tubing, cannulas for residents receiving oxygen. This equipment is to be discarded after use every 30 days." *"1. Tubing will be replaced by an oxygen service company/facility staff, once a Month, unless damage to tubing is noted." Review of the provider's April 2011 Oxygen and Nebulizer Administration policy revealed: *"4. See Oxygen Equipment and Procedure for cleaning nebulizer for cleaning and changing oxygen equipment." *It had not listed a process for replacing the tubing or nebulizer setup. Review of the provider's 8/11/08 Procedure for Cleaning Nebulizers policy revealed: *"After each use, the staff will disassemble the nebulizer and wash all items, Except tubing, in a hot water. The items will be air-dried." *"Replace each nebulizer tubing/set up monthly." Review of the provider's undated Policy and Procedure Manual and undated Medication Policy Book had no policies referencing the processes for cleaning and maintaining other respiratory devices.	S 085		
S 125	44:70:02:08 Linen The facility shall have distinct areas for the storage and handling of clean and soiled linens. Those areas used for the storage and handling of soiled linens must be negatively pressurized. The facility shall establish special procedures for the handling and processing of contaminated linens. Soiled linen must be placed in closed containers	S 125		

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S 125	Continued From page 4 prior to transportation. To safeguard clean linens from cross contamination, they must be transported in containers used exclusively for clean linens must be kept covered with dust covers at all times while in transit or in hallways, and must be stored in areas designated exclusively for this purpose. Written requests for any modification of the requirements of this section shall be reviewed and approved by the department before any changes are made. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to have effective processes implemented for the handling and laundering of soiled and contaminated linens to decrease or eliminate the risk of transmission or cross-contamination to other residents' personal linens, facility linens, and other areas for two of two randomly observed residents (5 and 6). Findings include: 1. Observation and interview on 8/29/23 at 10:50 a.m. with caregiver G revealed: *She was working that morning, but she normally worked the night shift. *Morning shift duties included collecting the residents' dirty laundry from their rooms and putting them into the laundry basket out in the hallway. *She indicated all residents' laundry was collected daily by the morning shift and brought to the laundry room. *It was then typically sorted in the laundry room and laundered during the night shift. Observation and interview on 8/29/23 at 11:05 a.m. with resident 5 in her room revealed: *Caregiver G entered the room with gloves on her	S 125	A policy will be composed regarding contaminated laundry to include bagging it separately, marking it as contaminated/soiled, and then how to process it separately. Admininstrator will contact the vendor and pest control company to ensure proper cleaning and disinfection of contaminated laundry and processing of laundry contaminated by bugs or pests. A bed bug policy, including how to handle and process laundry, will be composed with consultation from the pest control company. All staff will be educated by administrator and nurse regarding handling and processing of linens and the policies. Policies will be available in the laundry room and to staff. Contaminated laundry handling and processing will be monitored by the administrator daily for 2 weeks, then weekly for one month, then monthly. Monitoring results will be brought to the monthly leadership meetings for review.	10/15/23

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S 125	Continued From page 5 hands and indicated she was there for the resident's dirty laundry and garbage. *She went to the resident's bathroom, picked up the resident's dirty laundry from the floor, carried it against her clothes, picked up the resident's garbage can, and then left the room into the hallway. *In less than a minute she returned to the resident's room with gloves still on her hands and put the resident's garbage can back in the room. 2. Observation and interview on 8/29/23 at 1:50 p.m. and at 3:15 p.m. revealed resident 6 had evidence of live bed bugs on her white bed linens and on the mattress of her bed. Administrator A indicated the resident's bed linens were shared facility bed linens. She indicated they would wash the bedding and replace it with different shared facility bedding. Refer to S156. 3. Interview on 8/29/23 at 4:55 p.m. with unlicensed medication aide (UMA) D regarding the laundry process revealed: *She had worked there several years. *Facility staff laundered all residents' personal and facility linens together in the laundry room. -Day shift staff collected the dirty resident and facility laundry and put it in the laundry room. -Night shift staff typically washed, dried, and folded the laundry, some was done on day shift if they could not finish it all. -The clean laundry was delivered to the linen storage areas or the residents' room by the day or evening shift staff. *She was aware of bed bugs that had been found in random resident's rooms in the past. *She was not sure if there was a specific or different laundering process for those bed bug contaminated linens that came out of a	S 125		

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resident'sroom.
-She thought administrator A might have been the one to launder those items.

Observation on 8/30/23 at 8:05 a.m. in the laundry room revealed:
*There were two residential-style washing machines and two residential-style dryers.
*The washing machines were hooked up to dispensers attached to buckets of detergent, sanitizer, and fabric softener.
*A handwritten sign on the wall stated "Leave dials where they are set on the machine. Bulky warm water heavy load."
*A typed undated Laundry Instructions sheet was hanging on a cork board that included the following:
-"Each washing machine now has its own soap dispenser, one is located on the south wall and the other is on the wall by the window. The directions on how to switch from bleach and no bleach and how to start the soap is posted on the dispenser after selecting detertgent [detergent] you still have to select the machine cycle and press start on each washing maching [machine]."
-"Tuesdays - all the beds are stripped on Tuesdays so on that night there will be lots of bedding to do."

Interview on 8/30/23 at 8:15 a.m. with housekeeper F revealed:
*She worked two days a week and had been working there for several years.
*Her regular duties included cleaning the residents' sitting areas, vacuuming, and making the residents' beds.
*Occasionally she helped with facility and residents' personal laundry if the other staff were running behind.
*She did not know much about the laundry

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machines or the process.
-She would just start the machines since they were already set up at certain settings.
*She had helped strip the bed linens in rooms where they thought there could have been bed bugs.
-Staff put those bed linens in plastic bags and brought them to the laundry room.
*She was unsure if those contaminated linens were to have been washed differently than the other laundry or who was responsible for laundering them.

Interview on 8/30/23 at 8:40 a.m. with administrator A regarding laundry processes revealed:
*She had been the administrator for several years.
*Staff laundered all residents' personal linens and facility linens together after they were collected and sorted.
*The linen collected on 8/29/23 from resident 6's bed where there had been live bed bugs found had been laundered by her.
-She washed and dried the linens in their own separate load and used the same washer and dryer settings as all the other loads.
*Those washer and dryer settings were pre-set by their contracted chemical supply company.
*The facility's washers used chemicals for disinfection and not hot temperature disinfection.
*She was unsure if the pre-set washer and dryer settings would have been effective against bed bugs.
*When asked if their current laundry processes could have been contributing to the bed bug concerns she gave no response.
*She confirmed all laundry should have been handled and processed to ensure proper cleaning and disinfection and to ensure

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S 125	Continued From page 8 cross-contamination to other areas had not occurred. Interview on 8/30/23 at 10:00 a.m. with registered nurse B regarding laundry processes revealed: *She was not involved in the laundry processes of the facility or the staff training related to it. *She confirmed if contaminated linens were not handled or laundered properly there could have been a risk of infection control or other potential contamination concerns. *She had researched bed bugs in the past and thought the laundry should have been done on hot temperatures to have been effective. Interview on 8/30/23 at 12:40 p.m. with UMA C regarding laundry processes revealed: *She had worked there for several years. *All residents' personal and facility linens were laundered together. *She was not sure if there was a different process for laundering linens that were contaminated or potentially contaminated by bed bugs or who was responsible for that. Review of the provider's undated Policy and Procedure Manual and undated Medication Policy Book had no policies referencing the processes for handling and laundering of residents' personal or facility linens. Refer to S156.	S 125		
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 policies and procedures for the	S 131		

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S 131	Continued From page 9 handling and storage of potentially hazardous substances (including lab specimens). This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and manufacturer's label 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 disinfecting in the facility. *One of one observed housekeeper (F) used the same contaminated rags in multiple residents' rooms and had not been using a disinfectant product. *One of one sampled housekeeper (F) had not been trained related to infection control processes. Findings include: 1. Observation and interview on 8/30/23 at 8:15 a.m. with housekeeper F in the hallway revealed: *She worked two days a week and had been working there for several years. *Her regular duties included cleaning the residents' sitting areas, vacuuming, and making residents' beds. *She had a metal shopping cart in the hallway that contained the supplies she used. *In the cart she had a bucket of soapy water with a rag in it and one wet rag in her gloved hand. *She stated the bucket of soapy water contained Dawn dish soap and that if it was okay to kill everything on your dishes it should be good to kill germs in other places. *Her process with the rags was to use one in a resident's room while the other rag remained in	S 131	Housekeeper F and all staff have been educated on using separate rags for each resident's room during cleaning and disinfection to ensure no cross-contamination is occurring. All staff will be educated on the use of the facility's cleaners and disinfectants according to the manufacturer's guidelines for use. Instruction sheets for housekeeping processes have been reviewed and all staff will be educated on those by the administrator. Cleaning and disinfecting processes by the staff will be monitored by the administrator twice weekly for 1 month and then monthly. Results of the monitoring will be brought to the monthly leadership meetings to review.	10/15/23

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the soapy water bucket in the hallway.
-Then when she went to the next resident's room she would swap the rag she was using with the one in the bucket.
*Her process as she continued cleaning throughout the day was to swap the rag used in each room with the other in the bucket.
--If the rags got really dirty then she would change out the rags with new rags.
*She changed the bucket of soapy water periodically throughout her day when the water appeared dirty.

2. Review of employee F's personnel file and training records revealed:
*She was hired on 3/2/12.
*There was no documentation that she had received any training since she was hired.
Refer to S296, finding B

3. Review of the provider's undated Policy and Procedure Manual had no policies referencing the processes for cleaning, disinfecting, or housekeeping within the facility.

4. Interview on 8/30/23 at 10:00 a.m. with registered nurse B regarding the above revealed:
*Infection control processes should have been in place to ensure staff were trained and there were written processes for them to follow.
*Contaminated rags should not have been re-used in multiple residents' rooms.
*Staff should have used rags in only one resident's room and then should have gotten a new rag for a each resident's room.

Interview on 8/31/23 at 10:10 a.m. with administrator A regarding the above revealed:
*Housekeeper F had worked there several years and she confirmed she had no documented

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S 131	Continued From page 11 training. *The policy and procedure manual listed above contained their facility policies and if none were found on cleaning, disinfection, or housekeeping then there were none written. *She was aware housekeeper F used Dawn dish soap for wiping surfaces in the residents' rooms. -She thought that product should have been effective at killing all germs. -She was not aware it was not an EPA-approved disinfectant. *She had not been aware housekeeper F was using the same rags in multiple residents' rooms. -She should have been using a different rag for each resident's room. Review of Dawn Dish Soap's manufacturer's instructions and label revealed: *There was no mention of the product killing germs or that it was a disinfectant. *It was listed as a cleaner with the use of removing dirt and grease from any surface.	S 131	Unable to correct prior non-compliance for residents identified. The administrator, nurse, and housekeeper went to all residents' rooms to evaluate for potential bed bugs. Staff has removed some furniture including headboards and matresses. The facility is purchasing bed bug zippered covers for all residents beds and will put them on as soon as supplies arrive. The pest control company will be called for any new suspicions of a potential bed bug to evaluate for possible infestation and further treatment. A policy will be developed to ensure a program is implemented that is in accordance with current Department of Health/CDC guidelines for control and response to bed bugs in a healthcare facility. The pest control company will be contacted to conduct an inservice for all staff regarding bed bugs and appropriate detection and response to them. All staff will be educated by the administrator and nurse on bed bug policies for suspicion of bed bugs, notifications that should occur, responses that should occur, and follow up to concerns of bed bugs.	10/15/23
S 156	44:70:02:15 Insect and Rodent Control The facility shall take effective measures to protect against the entrance into the facility and the breeding or presence on the premises of rodents, flies, roaches, and other vermin. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to have an effective program in place for the follwing: *Monitoring, evaluating, and implementing interventions in response to initial suspicions of bed bugs or to prevent the reoccurrence of bed bugs for two of two randomly observed residents	S 156		

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S 156	Continued From page 12 (6 and 8) and seven other residents (2, 5, 10, 13, 16, 17, 18) who had concerns with bed bugs. *Documenting the occurrence of bed bugs throughout the facility including: when they were identified, where they were identified, and the facility's response to them. *Educating the staff and having written processes to effectively and efficiently respond to potential or actual bed bugs found in the facility. Findings include: 1. Observation and interview on 8/29/23 at 10:40 a.m. with administrator A regarding resident 2's room revealed: *The mattress for the bed was standing upright in the middle of the room. *A vacuum cleaner was next to the mattress. *Administrator A stated: -Resident 2 would not let staff clean the room. -Resident 2 was at a medical appointment. *She used that opportunity to try to deep clean the room. Interview on 8/30/23 at 9:45 a.m. with resident 2 in her room revealed: *Administrator A cleaned her room on 8/29/23 due to bed bugs. *That was the second time her room had been cleaned because of bed bugs. *Her room had been cleaned a month before. *She had known that was an ongoing issue. 2. Observation and interview on 8/29/23 at 11:05 a.m. with resident 5 in her room revealed: *She had no bed but had a brand-new lift chair that she slept in. *The facility had been having problems with bed bugs. *She was not aware of any bed bugs in her room, but had heard from several other residents who	S 156	A documentation process will be implemented to log suspicions or actual bed bugs found in the facility. The documentation will include the date, location, what response occurred, and any follow up in relation to the suspicion or actual bed bugs. Documentation will be reviewed during monthly leadership meetings to determine trends and if current interventions are working or if additional actions should occur. All staff will be educated to look for potential signs of bed bugs during their daily tasks including room cleaning and bed making. If there is any report of a potential bed bug the administrator will ensure proper follow up has occurred. All reports of potential bed bugs from a resident, visitor, or staff will be taken seriously and followed up on through the facility's new policies and processes. Monitoring of documentation and responses to bed bugs will be done twice weekly for a month and then monthly by administrator or designee. Monitoring will be brought to the monthly leadership meetings for review.	

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S 156	Continued From page 13 had concerns with them. 3. Observation and interview on 8/29/23 at 2:15 p.m. with resident 6 in her room revealed: *She complained of bug bites on her arms and abdomen and appeared anxious and distressed. -No visible bug bites were noted on her skin, but she was scratching those areas. *She stated there were bugs in her bed, but the staff had not believed her. -She said "they think I'm crazy." *Her bed was visibly disheveled with the comforter half-way off the bed and the white sheets exposed. -The bed frame and mattresses were pulled away from the wall at an angle. -The resident stated she did that herself while looking for the bugs. *Her white bed sheets had multiple brown spots noted on them. *There were white vinyl mattress covers on the box spring and on the mattress. -The vinyl mattress covers were open on the bottom side. 4. Observation and interview on 8/29/23 at 2:30 p.m. with resident 10 in his room revealed he had: *Been there for approximately one and one-half years. *His own room and furniture and the room looked tidy. *Heard of beg bugs in the facility and was not sure what was being done about that. 5. Observation and interview on 8/29/23 at 3:00 p.m. revealed: *Resident 8 walked to the nurse's office looking for administrator A. *She was using a front-wheeled walker and held	S 156		

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S 156	Continued From page 14 a tissue in her right hand. *She stated "They didn't believe me" and complained of bug bites on her neck. *She opened the tissue and showed a live sesame seed-sized bug that moved quickly, so she closed the tissue back up. -She indicated it was a bed bug she had found in her room. Continued observation and interview on 8/29/23 at 3:10 p.m. revealed: *The surveyors assisted resident 8 to find administrator A. *When resident 8 showed administrator A the bug in the tissue, the administrator took it from her and went across the hall into another resident's room to flush it down the toilet. *Surveyors then asked administrator A what happened next when a bug was identified in the facility. -Administrator A indicated she would look at the resident's bed to see if she saw any more. *Resident 8, administrator A, and the surveyors went into resident 8's room down another hallway where administrator A briefly looked at the resident's recliner. -She indicated she had not seen any bugs. *She was promtped about where else to look for potential bugs. -She indicated the bed and stated the resident's mattress was brought in by a home medical company when she was admitted there. -There was an additional foam eggcrate-style pad on top of the mattress under the sheets. *Administrator A indicated she was not sure if the bug she had flushed was a bed bug or not. -She stated a pest control company had been there the week before and had sprayed a different resident's room for bed bugs. -That was resident 16's room down a different	S 156		

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hallway.
-A copy of invoices from the pest control companies for any bed bugs response was requested at that time.
*Surveyors then requested administrator A go to resident 6's room to check out her bedding and mattress.

6. Observation and interview on 8/29/23 at 3:15 p.m. with administrator A and resident 6 in her room revealed:
*Resident 6's room was on the opposite side of the building from resident 8's room.
-Her room was also in a different hallway and area from resident 16's room where the administrator indicated bed bugs had been sprayed for the previous week.
*Administrator A indicated staff had called her on 8/27/23 and told her about resident 6 complaining of bugs.
-The staff had not thought that they were bed bugs.
*The bedding on resident 6's bed remained disheveled as it had been at 2:15 p.m. that day.
*Administrator A confirmed there were multiple brown spots on the white sheets which could have indicated bed bugs.
*Administrator A checked the sheets and found a live bug crawling on the sheets near the foot of the bed.
-She picked that bug up with her gloved hand.
*At the request of the surveyor she looked under the sheets and the vinyl mattress cover on the mattress seam and another live bug was found near the foot of the bed.
-She picked that bug up with her gloved hand as well.
*The resident stated she knew there were bugs in her bed.
*Administrator A confirmed the bugs were in the

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S 156	Continued From page 16 resident's bed. *The administrator indicated she would call the pest control company. -She stated the staff would remove the resident's bedding, bag those linens up, and then bring them to the laundry room. 7. Interview on 8/29/23 at 4:02 p.m. with resident 13 in his room revealed: *Administrator A had resident 13 and a community member haul a couch and mattress to the dump on 8/26/23. *Administrator A would not let resident 13 know which room the furniture came out of. *He stated the furniture was removed because of bed bugs. Interview on 8/30/23 at 8:25 a.m. with resident 13 in the hallway by his room revealed he: *Found a bed bug by the light switch in his bathroom that morning. *Flushed it down the toilet. *Stated it would have done no good to report it to administrator A. 8. Interview on 8/29/23 at 5:00 p.m. with unlicensed medication aide (UMA) D regarding bed bugs revealed: *She had worked there for several years. *She had heard bed bugs were found in some residents' rooms. *She thought administrator A had been spraying for the bed bugs and some furniture had been removed from the facility related to bed bugs. -Resident 17's chair was removed the previous weekend. -Resident 18's couch had been removed a few weeks ago. *If staff found a bug or evidence of bugs they would have let administrator A know about it.	S 156		

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S 156	Continued From page 17 -She was not sure what happened after that. *If staff were told to, they would have bagged up the resident's bed linens and brought them to the laundry room. -She thought administrator A washed the bedding that was bagged up but was not sure. *She was not sure what the process for bed bugs was and had no training on that topic. *She stated to ask administrator A about the process since she was not aware. 9. Further interview on 8/29/23 at 5:15 p.m. with administrator A in her office regarding bed bugs revealed: *She had called a pest control company and they were going to come spray resident 6's and resident 8's rooms that evening. *If the pest control company was not able to make it she would spray them herself. *She held up a purple aerosol can that was labeled Bed Bug and Lice Killer. -She indicated she could use that to spray their beds. *There was a stack of new vinyl mattress covers on the floor of her office. -She indicated those were meant for incontinence protection for the mattress, not for bed bugs. --Those were the same style that were on resident 6's mattress and box spring. *When questioned how to protect residents 6 and 8 from sleeping in their beds that night when there were known bugs she had no response. -The surveyor questioned if there were other mattresses available and she indicated she could possibly do that for resident 6, but resident 8's was a special mattress from a home medical equipment store. *She indicated they would ensure the rooms were sprayed and the bedding taken care of that night before the resident's bedtime.	S 156		

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S 156	Continued From page 18 *She gave a copy of a pest control company invoice and indicated that was the only invoice she had. -The invoice indicated a "One Shot Service - Bedbug Treatment [resident 16's room]" had occurred on 8/22/23. 10. Interview on 8/30/23 at 10:00 a.m. with registered nurse (RN) B regarding bed bugs revealed: *She had heard of concerns of bed bugs in the facility over the past several months. *She indicated resident 10 had concerns with bed bugs in his room in the past. -They had a pest control company come and spray his room and some items were removed from the facility due to potential infestation. *She had heard of bed bugs that had been in different rooms throughout the facility. -If a staff or resident reported seeing a bug that would get reported to administrator A. *She stated they had two different pest control companies in the facility over the past several months. -She was unsure how often or on which dates they had sprayed, but administrator A should have had records of that. 11. Interview on 8/30/23 at 12:40 p.m. with UMA C regarding bed bugs revealed: *She had worked there for several years and had no training on bed bugs. *She was not sure what the process was for responding to them. *If she found a bug, she would kill it. -If she thought it was bed bugs or the resident reported bugs to her she would have informed administrator A about it. *She had heard of bed bugs in different residents' rooms and different areas of the facility in the	S 156		

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S 156	Continued From page 19 past. 12. Interview on 8/30/23 at 3:45 p.m. with UMA J regarding bed bugs revealed: *She had worked there for several years and had no training on bed bugs. *She was not sure what the process was for responding to them. *If a resident reported bugs to her she would have informed administrator A about it. *She had heard of bed bugs in different residents' rooms and different areas of the facility in the past. *She thought bed bugs had been found in resident 18's room first. 13. Interview on 8/30/23 at 4:00 p.m. with contracted pest control company technician K revealed: *He was there that day to spray for bed bugs in a resident's room related to a call they had received on 8/29/23. *He had been there approximately five times since May 2023 spraying for bed bugs. -They seemed to have been found in different areas of the building during each of his visits. -Usually, he found a live bed bug or two or dead bugs when he came to spray the rooms they had reported them in. *He had not done a full inspection or evaluation of the building or additional rooms during the visits. -They evaluated the room it was reported in and sprayed that room. *When asked which room he sprayed that day he first stated resident 19's room, but then indicated it was resident 6's room. -Those two residents' rooms were on opposite sides of the building and in different hallways. -He had not mentioned spraying in resident 8's room where the other live bug was found on	S 156		

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S 156	Continued From page 20 8/29/23. *He was had not asked the staff about the facility's laundry processes for resident and facility linens to see if that was related to the bug problems. *He confirmed: -Contaminated linens should have been washed and dried with hot temperatures to ensure the bugs and/or their eggs were killed. -If linens were not handled or laundered properly that could have contributed to the continued concerns with bed bugs and the bugs that were found in different areas of the building. *When asked about additional visits for spraying he indicated they would just come back when staff called with another report. -The spray they used was meant to have been a one time spray, but sometimes they had to return and spray the same room again. *He confirmed bed bugs were a pest control issue and processes should have been implemented to respond to and eradicate them. -Processes should have included vacuuming and effective laundry processes, along with spraying and other treatments if needed. -Sometimes they recommended removing furniture or beds as well. 14. Observations and interviews during the survey revealed concerns with the laundering process of contaminated linens which could have contributed to the bed bug concerns in the facility. Refer to S125. 15. Interview on 8/31/23 at 10:10 a.m. with administrator A revealed: *There were no written policies or processes for the staff to follow to respond to initial or recurrent bed bugs. *Staff had not been trained regarding bed bugs	S 156		

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S 156	Continued From page 21 including what to look for, how to respond, or what other interventions should have been done. *There was no documentation to support the facility's efforts regarding bed bug response or processes. *She had not reached out to other entities for guidance on how to respond to bed bugs, other than the pest control company. *They had used a different contracted pest control company in the past. *It was difficult to get any pest control company to the facility quickly, or on a regular basis, due to their rural location in the state. *She confirmed pest control was the facility's responsibility and she was the oversight of the operations of the facility as the administrator.	S 156		
S 167	44:70:02:17(3) Occupant protection The facility shall take at least the following precautions: (3) Provide an emergency staff call system for resident use to summon assistance from staff. The system must be capable of being easily activated by a resident and must register both visually and audibly at the staff station. The system must be utilized and maintained in a manner to ensure it is a consistent and effective means for a resident to alert staff of the need for assistance. The call system must also meet at least one of the following requirements: (a) The call system utilizes fixed call stations convenient for resident use and activated by a pull cord or other approved device. The fixed call stations must be located at each bed, toilet, and bathing facility used by a resident. (b) The call system is a wireless system with devices carried by a resident; or (c) The call system is another type of call	S 167		

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S 167	Continued From page 22 system that has been submitted for review and approved by the department; A call station or device is not required in the resident room of a cognitively impaired resident if a nursing assessment determined the resident would not benefit from the availability. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and testing, the provider failed to ensure all residents including five residents that were interviewed (2, 5, 11, 14, and 20) had a working pendant call system to call for assistance from the staff when needed. Findings include: 1. Observation and interview on 8/29/23 at 11:05 a.m. with resident 5 in her room revealed: *She had lived there for several years and had been in a few different rooms. *She stated she had no way to call the staff for help unless she used her cell phone. *There was a call light string attached to a switch on the wall behind her recliner. -That string was tied up and not accessible to her. *She would have liked to have a call pendant like some of the other residents. 2. Observation, interview, and testing of the call system on 8/29/23 at 1:45 p.m. with unlicensed medication aide C regarding the resident's call system revealed: *The call system that was located on the walls in resident's rooms was an old system that was not used anymore. -If the resident pulled that call string it would light	S 167	All residents, including residents 2, 5, 11, 14, and 20, have working call pendants now. All staff have been educated that all residents should have a call pendant. If a call pendant is not working they should notify leadership for potential fixing or replacement. If the pendant can not be fixed right away there will be a spare pendant kept on the med cart available for use. There is also an instruction manual for the call pendants available to the staff. The nurse will verify the residents have their pendants available and working during her weekly assessments. Monitoring of the call pendants will be done by the administrator or designee twice weekly for one month and then monthly. Results of the monitoring will be reviewed during the monthly leadership meetings.	10/15/23

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S 167	Continued From page 23 up on a panel in the hallway but it would not make any sound to alert the staff. *The residents' call pendant system was what most of them carried like a necklace or had on a chain or string. *When the resident used the call pendant it would alert to a pager that was carried by the staff. -The staff would then have to respond directly to the resident and reset it on their pendant. *Some residents had called staff from their phones instead of using the call pendant. 3. Interview and observation on 8/29/23 at 2:15 p.m. with resident 2 while in her room revealed: *She had moved into the facility in March 2023. *There was a call light string attached to a switch on the wall behind her bed. *She was not sure if it worked. *She knew other residents had pendants they wore around their neck. *She would have liked to have a pendent when she used the bathroom. *There was not a call light in her bathroom to have used to call for assistance if needed. 4. Interview on 8/29/23 at 3:40 p.m. with resident 11 in his room revealed: *He had moved there in June 2022. *He had no call pendant to call the staff for help when he needed it. *Administrator A told him those call pendants were only to have been used in an emergency and he could call the staff with his cell phone. *He knew other residents had a call pendant to use. 5. Interview on 8/29/23 at 4:15 p.m. with resident 14 in his room revealed: *He was given a call pendant when he moved in. *It quit working a few months ago.	S 167		

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S 167	Continued From page 24 *He had given it to the administrator so it could have been fixed. *He had never received it back. 6. Interview on 8/29/23 at 4:30 p.m. with resident 20 in her room revealed she: *Had lived there for several years. *Was informed by staff she could use her cell phone to call them for help. *Had no call pendant and wanted one. *Had a call pendant in the past that had not worked, staff had taken it and they had never replaced it. 7. Interviews on 8/30/23 at 10:00 a.m. and again at 4:25 p.m. with registered nurse B regarding residents' call pendants revealed: *All residents should have had a call pendant to call staff for help when they needed it. *Some residents had no call pendant and she was not sure why. *She was not sure which residents had a call pendant and which ones had not. *She indicated the call pendants were assigned to the residents by administrator A. 8. Interview on 8/31/23 at 10:10 a.m. with administrator A regarding residents' call pendants revealed: *She confirmed the call system on the walls in the residents' rooms was the old system and it was not fully functional. *The call pendants were the active call system residents should have used. *She was not sure why some residents had no call pendant. *She thought some residents preferred to use their cell phones instead of having a call pendant. *There were enough call pendants for all residents in the facility to have one.	S 167		

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S 167	Continued From page 25 *She confirmed all residents should have had a call pendant that was functioning and available for them to use.	S 167		
S 215	44:70:03:03 Fire extinguisher equipment Fire extinguisher equipment shall be installed and maintained by to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to perform monthly checks of one randomly observed fire extinguisher (across from administator's office). Findings include: 1. Observation on 8/29/23 at 11:43 p.m. revealed the fire extinguisher in the corridor near the administrator's office room indicated there were not monthly maintenance checks written on the fire extinguisher tag. Interview with the administrator at the time of the observation confirmed that finding. She indicated	S 215	The July monthly inspection was missed by the administrator. The annual inspection had been done by the fire inspection company in June 2023 and some of the fire extinguishers had been replaced. August monthly inspection was done on 8/29/23. It will now be marked on the administrator's calendar to complete the monthly fire extinguisher inspection on the 15th of each month. The dated tag will be flipped so it faces forward and can be seen from the enclosed case. This will make it more noticeable to be seen. The monitoring of the monthly fire extinguisher documentation will be done by the housekeeper monthly. Monitoring results will be reported to the monthly leadership meetings for review.	10/15/23

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S 215	Continued From page 26 the annual inspection of the extinguishers in the building had recently occurred. Further observation revealed the Fire extinguisher company had performed the annual in June 2023, no inspection of the extinguisher had been performed for July and the month of August up to that point (8/29/2023). Continued observation revealed the same condition existed for all fire extinguishers in the building.	S 215		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and job description review, the administrator failed to manage the facility in a manner that ensured the overall daily management of the facility, appropriate resident care, resident safety, and maintained compliance with the Administrative Rules of South Dakota (ARSD) 44:70 Assisted Living Center regulations. Areas of concern included the following: *Cleaning methods and infection control. *Linen handling and processes. *Insect and pest control. *Occupant protection related to the staff call system. *Fire safety equipment and fire drills.	S 280	Administrator has read the 44:70 rules and the areas of deficient practice. Administrator will ensure the POC for all tags is being followed and will ensure documentation to support the POC is being done. The administrator will implement a new quality meeting with the nurses and owner to discuss systems and monitoring for areas of deficient practice and quality of care and services within the facility. These leadership meetings will be monthly with the possibility of changing to quarterly in the future.	10/15/23

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S 280	Continued From page 27 *Personnel training. *Pneumonia vaccination requirements. *Safe disposal of used insulin needles. *Storage of medications to prevent access by unauthorized individuals. *Accountability processes for controlled medications and medications awaiting destruction. *Disposal processes of expired medications and medications for discharged residents. *Having presciption medications available without proper labeling according to physician orders and requirements. *Ensuring documentation that residents had been informed of their resident rights upon admission. *Ensuring documentation that residents had signed an admission agreement. *Having an effective and documented grievance process. Findings include: 1. Interview on 8/31/23 at 10:10 a.m. with administrator A revealed: *She had been the administrator for several years. *As the administrator she was responsible for oversight and daily operations of the facility. *She was aware of the ARSD requirements for assisted living centers. *She confirmed there were multiple areas of deficient practice identified during the survey as indicated above. Review of the provider's Administrator job description revealed: *"The Administrator is fully responsible for community operations and quality of care. Financial stability of the community, staffing practices and day to day operations are coordinated by the Administrator to fall within the	S 280		

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S 280	Continued From page 28 operational guidelines of governmental agencies..." *Responsibilities of the Administrator included the folllowing: -Maintain compliance with regulatory agencies. -Develop policy and procedures for resident care. -Utilize management that monitors quality standards on an ongoing basis in all departments. Refer to S085, S125, S131, S156, S167, S215, S296, S320, S337, S630, S632, S642, S654, S775, S790, and S845.	S 280		
S 296	44:70:04:04 Personnel training Ongoing education programs must cover the required subjects annually. These programs must be completed within 30 days of hire for all healthcare employees and must include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (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, neglect, and misappropriation of resident property and funds;	S 296		

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S 296	Continued From page 29 (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 employee education necessary based on the individualized resident care needs provided by the healthcare employees to the residents who are accepted and retained in the facility. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 8/29/23 at 2:11 p.m. revealed the most recent documentation for fire drills that had been conducted was on 10/26/21. Interview with the administrator at the time of the record review confirmed those findings. She stated she was aware the minimum number of fire drills per the required frequency had not been met for each shift for 2021, 2022, and 2023. The deficiency had the potential to affect 100% of the occupants of the building. B. Based on employee file review, training records review, interview, and policy review, the provider failed to ensure staff had completed mandatory training during initial orientation and annually for three of five sampled employees (B, F and I). Findings include: 1. Review of employee B's personnel file and training records revealed: *She was hired on 4/9/20. *There was no documentation she had completed	S 296	A fire drill will be conducted to ensure staff and residents are familiar with the procedure, this will be documented. All staff will be educated by the administrator on the process for fire drills to ensure residents' safety. The fire drill binder will have a form filled out for each month and which shift the drill should be performed for that month to schedule them ahead of time. The fire drill documentation will include which staff participated in a drill. A list of residents and staff will be in the binder and their name will be checked off when they participate in a drill. This will be documented by the administrator. Monitoring of the fire drills and documentation will be done monthly at the leadership meetings. Staff B, F, and I will complete the mandatory training and all other employees will be reviewed to ensure their training has been completed as required. A new Avera Education Mandatory Extravaganza 2022 and 2022 caregiver continuing education DVDs were ordered and received on 9/22/23. All current staff will view the DVDs and be given handouts that go along with them. This will be done annually in May of each year. The administrator will add the annual education reminder to her calendar to ensure it is scheduled and completed by all staff. Documentation of the staff training will be put into each staff's employment file. Monitoring of staff training will be reviewed at the monthly leadership meetings.	10/15/23

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annual training in the last year for the following required topics:
-Fire drills quarterly for each shift.
-Emergency procedures and preparedness.
-Infection control and prevention.
-Accident prevention and safety procedures.
-Resident rights.
-Confidentiality.
-Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism.
-Nutritional risks and hydration.
-Abuse, neglect, and misappropriation of resident property and funds.
-Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors.
-Admission and retention of residents with communicable diseases, infection control measures, and information about the state's reportable diseases list.

2. Review of employee F's personnel file and training records revealed:
*She was hired on 3/2/12.
*There was no documentation that she had received any training since she was hired.

3. Review of employee I's personnel file and training records revealed:
*She was hired on 7/11/23.
*There was no documentation she had completed initial orientation for the following required topics in the first 30 days of employment:
-Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism.
-Nutritional risks and hydration.
-Abuse, neglect, and misappropriation of resident property and funds.
-Problem solving and communication techniques RT residents with cognitive impairment or

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S 296	Continued From page 31 challenging behaviors. -Admission and retention of residents with communicable diseases, infection control measures, and information about the state's reportable diseases list. Interview on 8/31/23 at 9:15 a.m. with administrator A revealed: *The provider had not completed initial or annual training for nursing, housekeeping or dietary staff. *She thought it only pertained to caregivers and medication aides. *She agreed the staff listed above had not completed the required education and training. Review of the provider's undated staff training policy revealed: *"Direct care staff will receive initial orientation and ongoing in-service training based on state regulations an the needs of the residents being served in the community. 1. Training on the following topics is included during caregiver orientation training and ongoing in-services. a. Professional and ethical conduct, confidentiality, and reporting requirements. b. Promoting resident dignity, independence, privacy, self-determination, choice and resident rights. c. Abuse, neglect, exploitation and reporting requirements. d. Fire, safety and emergency procedures, including identification of unsafe environmental factors. e. Infection control and Standard Precautions. f. Emergencies, evacuations, disasters, incident reporting. g. Advanced directives and Do-Not-Resuscitate Orders. h. Psychosocial care and social, recreational	S 296		

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S 296	Continued From page 32 activities. i. Diversity: cultural, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, language, ethnicity, racial issues, etc. j. End of life care and ethical issues. k. Special care needs, aging issues, age-related limitations. l. Providing physical care, assisting with ADLs, encouraging independence, lifting and transferring techniques, use of care equipment (e.g. lifts). m. Nutritional issues. n. Documentation and record keeping. o. Service plans, assessments, appraisals, resident summaries, person-centered care, and end of shift reports. p. Dementia care, managing behavioral challenges, wandering and elopement (as applicable). q. First Aid and CPR (as applicable) r. Medication management (as applicable). 2. All training will be documented. Copies of documentation will be retained in the employee record."	S 296		
S 320	44:70:04:08 Prevention and control of pneumonia Each facility shall arrange for immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage residents to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not	S 320		

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S 320	Continued From page 33 met as evidenced by: Based on record review and interview, the provider failed to ensure four of seven sampled residents (2, 5, 6, and 7) had documentation that a pneumonia vaccination had been offered and either administered or declined. Findings include: 1. Review of resident 2's care record revealed: *Her admission date was 3/6/23. *There was no pneumonia vaccination documentation. 2. Review of resident 7's care record revealed: *Her admission date was 9/2/22. *There was no pneumonia vaccination documentation. 3. Review of resident 5's care record revealed: *Her admission date was 10/12/21. *She had admitted to the facility from another assisted living center. *There was no pneumonia vaccination documentation. 4. Review of resident 5's care record revealed: *Her admission date was 5/16/23. *She had admitted to the facility from a skilled nursing facility. *There was no pneumonia vaccination documentation. 5. Interview on 8/31/23 at 9:45 a.m. registered nurse B revealed: *There was no documented pneumonia vaccination information in the above residents' care records. *She agreed there should have been documentation for the pneumonia vaccine that was either administered to or refused by the resident.	S 320	All residents charts have been reviewed by the nurse and administrator for immunization documentation. All residents have either had their pneumonia vaccination or have a refusal documented. The nurse will will ensure vaccination documentation is completed for all new admissions. Their is a checklist for new admissions that includes vaccinations to help ensure the documentation is completed. The administrator will monitor the documentation for vaccinations on all new admissions. Results of the monitoring will be reviewed at the monthly leadership meetings.	10/15/23

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S 320	Continued From page 34 *She would have to follow up with the physicians on that. The provider could not produce a policy for resident vaccination and documentation.	S 320		
S 337	44:70:04:11 Care policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, manufacturer's label review, and policy review, the provider failed to ensure one of one observed unlicensed medication aide (UMA) C had performed safe handling and disposal of a used needle following insulin administration by two of two observed residents (5 and 9) creating a risk of needle stick injury. Findings include: 1. Observation and interview on 8/29/23 at 11:45 a.m. with UMA C during resident 5's insulin administration revealed: *UMA C brought the resident's Humalog insulin pen into the resident's room. *She assisted the resident to perform her insulin self-administration by attaching a new needle to the pen and ensuring an accurate dose of insulin was set. *She then removed the cap from the needle and handed the pen device to the resident. *The resident self-injected the insulin into the skin of her abdomen. *When the resident finished her injection she	S 337	Unable to correct prior non-compliance for residents identified. An inservice will be presented to all employed med aides for proper handling and disposal of needles and insulin pens. A hands on demonstration will be presented by the nurse. All meds aides were educated on the UltiGuard SafePack disposal system. The pharmacy will supply the UltiGuard Safe Pack for all residents using insulin pens. The nurse will monitor insulin administration and needle handling/disposal twice weekly for one month and then monthly. Results of the monitoring will be reviewed at the monthly leadership meetings.	10/15/23

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S 337	Continued From page 35 handed the insulin pen device with the used needle attached back to the UMA. *UMA C recapped that used needle with the plastic cap that was previously on the needle. *She then spun the used needle and cap off the insulin pen. *She opened the resident's bathroom cabinet and put the used re-capped needle into the top of the UltiGuard Safe Pack container and spun the dial which then deposited it into the container. *The plastic UltiGuard Safe Pack container held new insulin pen needles in the bottom compartment and had an opening at the top for the disposal of the used pen needles. -The product label indicated it was for convenient dispensing and safe sharps disposal. *UMA C indicated that was her usual process and left the resident's room with the insulin pen to put it back into the medication cart. Review of the manufacturer's instructions on the side of the UltiGuard Safe Pack container following the above observation revealed: *The instructions included a step-by-step process to ensure safe removal of the used needle including the following directions: -"1. Remove pen needle from storage. Use pen needle as directed. Do NOT attempt to recap needle!" -"2. After giving the injection, leave pen needle on pen injector. Carefully insert pen needle tip into center of red opening on top of the UltiGuard Safe Pack and push in with slight pressure. Do not push into opening with excessive force." -"3. Rotate pen injector counter-clockwise to remove pen needle from pen. Store pen as directed." -"4. Turn the UltiGuard Safe Pack's handle a full 360 degrees to eject pen needle into container. If pen needle did not eject, rotate handle again until	S 337		

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pen needle is ejected."
*The reference also had illustrations which included the following:
-To put the used uncapped needle directly into the top of the pack.
-To spin the pen device counterclockwise to safely remove the needle.
-After the needle was removed from the pen, to use the dial on the side of the container to put the needle into the sharp's device.

Observation and interview on 8/30/23 at 7:50 a.m. with UMA C during resident 9's insulin administration revealed:
*She walked with the resident to a shower room near the dining room for privacy.
*She brought the resident's Lantus insulin pen and assisted the resident to perform his insulin self-administration.
-She attached a new needle to the pen and ensured an accurate dose of insulin was set.
*She then removed the cap from the needle and handed the pen device to the resident.
*The resident self-injected the insulin into the skin of his abdomen and handed the insulin pen device with the used needle back to the UMA.
*UMA C recapped that used needle with the plastic cap that was previously on the needle.
*She then spun the used needle and cap off the insulin pen.
*She walked back to the medication cart in the dining room and disposed of the re-capped used needle in the sharp's container on the side of the medication cart.

Interview with UMA C immediately following the above observation revealed:
*Her usual process was to recap the used needle, spin the recapped needle off with her hands, and then put that recapped needle into the sharps

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disposal container or the UltiGuard Safe Pack container if the resident had one of those.
*She was not sure how the UltiGuard Safe Pack container worked and was unsure if she had been trained on its use.
*She was careful when recapping used needles.
*She agreed recapping used needles was not a safe practice and it created a risk of a needle stick injury.

Interview and review of the UltiGuard Safe Pack instructions on the side of the container stored in resident 5's room with UMA C on 8/30/23 at 9:10 a.m. revealed:
*She had not seen those instructions before and had not recalled being trained on removing the needles according to those instructions.
*She confirmed she had not followed the instructions when she removed the needle following residents 5's observed insulin administration on 8/29/23.
*She indicated they had several residents who used insulin pens.
-At least two of them had the UltiGuard Safe Pack containers for disposal of their needles.

Interview and UltiGuard Safe Pack instructions review on 8/30/23 at 11:45 a.m. with registered nurse (RN) B revealed:
*She confirmed safe handling and disposal of used needles had not occurred in the above observations.
*Needles should not have been recapped as that was not a safe practice.
*Used needles should have been handled and disposed of in a way to ensure needle stick injuries would not occur.
*She was not aware of the manufacturer's instructions and was not sure if the UMA staff were either.

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S 337	Continued From page 38 *Staff should have followed those instructions to ensure safe disposal of used needles occurred after using them. *The other RN that worked for the facility completed the UMA training and yearly competencies for all UMAs. -She was not sure if safe used needle disposal was part of that training. Review of the provider's undated Injections policy revealed: *"Syringes and needles are disposed of in a 'container for sharps,' and the container shall is [be] kept inaccessible to residents..." *There was no information regarding the process to ensure safety when handling used needles or not recap a used needle.	S 337		
S 630	44:70:07:04 Storage and labeling of medications All drugs or medications shall be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for drug storage, and inaccessible to residents, or visitors at all times. Medications suitable for storage at room temperature shall be maintained between 59 and 86 degrees Fahrenheit (15 and 30 degrees centigrade). Medications that require refrigeration shall be maintained between 36 and 46 degrees Fahrenheit (2 and 8 degrees centigrade). This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, observation, and policy review, the provider failed to ensure medications stored in one of one medication cart and in one of one administrator's office had been secured in a manner to prevent access by unauthorized	S 630		

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S 630	Continued From page 39 individuals. Findings include: 1. Interviews on 8/29/23 at 1:45 p.m. and again on 8/30/23 at 9:10 a.m. with unlicensed medication aide (UMA) C regarding the medication storage in the facility revealed: *She had worked there for several years, primarily on the day shift. *There was one medication cart for the facility. *Keys to the medication cart were kept by the UMA assigned to administer medications during their scheduled shift. *When the day shift UMA left they handed the keys to the evening shift UMA. *When the evening shift UMA left they handed the keys to the night shift staff. *Sometimes the night shift had a UMA on duty but there were nights there was no UMA scheduled for the night shift. -Those nights had caregivers who had not been trained as UMAs. *They only had one night shift UMA. -She typically worked four nights a week, leaving three nights a week with no UMA on duty. *On the nights when no UMA was scheduled the medication cart keys were given to the caregiver assigned to the kitchen end of the building. *The night shift caregiver then had the medication cart keys all night and would give them to the day shift UMA when they arrived in the morning. *She confirmed medications should have been secured from unauthorized individuals at all times. -Caregivers would not have been authorized to have access to the medications in the cart. *She was unsure what they should have done with the medication cart keys when there were no UMAs or nurse in the building at night. Interview on 8/30/23 at 4:55 p.m. with UMA D	S 630	The unsecured medications in the administrator's office were moved to a locked cabinet. A new process has been implemented for the med cart and med storage keys when the staff is not a med aide to have access to those keys. On nights when a med aide is not scheduled the evening shift med aide will put the med cart/storage keys into a locker with a combination lock at the end of their shift. The morning med aide would retrieve those keys when they arrive for their shift in the morning. If a med aide does come into the facility during the night for a medication administration they would be able to access the locker if needed for the med keys. The combination lock code will only be given to qualified med aides or nurses. Med aides will document on the count sheets related to the med keys. Monitoring of the key storage and count sheets will be done by the administrator or designee. When medications are delivered to the facility they will be put into the locked medication room or locked medication cart promptly by qualified staff. Monitoring of this will be done by the administrator or designee daily. Results of the monitoring will be reviewed at the monthly leadership meetings.	10/15/23

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S 630	Continued From page 40	S 630		

regarding the medication storage in the facility revealed:
*She had worked there several years, primarily on the evening shifts.
*She confirmed the same process that UMA C stated above.
*She agreed medications should have been secured from unauthorized individuals at all times.

2. Observation on 8/29/23 at 5:15 p.m. in administrator A's office revealed what appeared to have been medication boxes and bottles sitting on a shelf behind the desk in her office. Administrator A was in her office at that time.

Interview on 8/30/23 from 10:00 a.m. through 11:00 a.m. with registered nurse (RN) B regarding several topics including medication storage in the facility revealed:
*All medications should have been secured from unauthorized individuals at all times.
*She agreed the medication cart keys should not have been given to caregivers that were not trained as UMAs or authorized to have access to medications.
-She was not aware that was occurring on the night shifts on a regular basis.
*When asked about the medications in administrator A's office she had not been aware of them.

Observation and interview on 8/30/23 at 11:00 a.m. with RN B in administrator A's office to review the medications that were stored in there revealed:
*The office had a lot of miscellaneous items stored all over within the space.
*On a cabinet behind the desk there were multiple random resident's medications sitting out

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S 630	Continued From page 41 in the open. -They were not locked and were not secured. -The door had been open with no one in the office when the RN and surveyor arrived. --Residents had been walking in the hallway outside the office. *RN B indicated the medications appeared to have been for current residents and residents who were no longer residing there. *The random residents' medications were prescription and over-the-counter medications including the following: -Inhaled medications. -Oral medications. -Topical medications. *She agreed the medications should not have been stored that way. -They should have been secured from unauthorized individuals. During the above observation and interview administrator A arrived in her office. Interview with her revealed: *She confirmed the medications above had been left out and were not secured. *She was aware medications should have been secured at all times. *She was aware the evening shift staff gave the medication cart keys to the night shift caregiver if there was no UMA scheduled for night shift. *When asked about the medication cart keys she confirmed caregivers were not considered authorized staff to have access to medications. Review of the provider's revised 8/11/08 Medication Control and Storage policy revealed: *"2. Will have proper storage of prescribed medications which is inaccessible to residents or visitors...All drugs will be stored in the med cart and locked unless requiring refrigeration..."	S 630		

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S 630	Continued From page 42 Review of the provider's revised April 2011 Job Description for Unlicensed Assistive Personnel in the Medication Policy Book revealed: *"There is no margin for error!" *"19. A medication is never left unattended in any area."	S 630		
S 632	44:70:07:04 Storage and labeling of medications The medications or drugs of each resident for whom medications are facility-administered shall be stored in the containers in which they were originally received and may not be transferred to another container. Special modification of this requirement may be made if single dose packaging is used. Each prescription drug container, including manufacturer's complimentary samples, shall be labeled with the resident's name, physician, physician assistant, or nurse practitioner's name, drug name and strength, directions for use, and prescription date. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to have a process in place for resident medication orders that were received outside of normal business hours to ensure they were pharmacist labeled according to the physician's orders with instructions for their use. The facility had a stock supply of multiple prescription medications in one of one administrator's office that were not labeled for individual resident's use. Findings include: 1. Observation and interview on 8/30/23 at 11:00 a.m. with administrator A in her office revealed: *There was a four-drawer locked file cabinet with	S 632	The emergency kit of medications was removed from the facility by the pharmacist. The facility will no longer stock emergency presciption medications. The contracted pharmacy is working on a process with the other local pharmacies to provide medications if/when they are ordered outside of the normal pharmacy hours including getting enough doses for a new medication until the pharmacy is able to fill and deliver the medication. The nurses and administrator will be educated by the pharmacy on the updated process. All residents' medications will be filled by a pharmacy and appropriately labeled for their use. Nurses will be in communication with the clinic/provider and the pharmacy if a resident gets a new medication order outside of normal business hours to ensure the resident's needs are met. The updated process will be reviewed at monthly leadership meetings to ensure the process is working.	10/15/23

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S 632	Continued From page 43 medications stored in it. *Administrator A retrieved a set of keys from her desk and unlocked the file cabinet. *She opened the third drawer of the cabinet which had a locked storage area within it. *Using a different key she opened that locked area which included a plastic container with a handwritten label of "starter box." *She called the plastic container an "emergency kit." *The plastic container held multiple prescription medications in plastic bottles and envelopes. -The bottles and envelopes had different labeling from different pharmacies. *The prescription medications included several different types of antibiotics, blood thinners, and steroids. *None of the medication bottles or envelopes had resident-specific labeling to include their instructions for use and prescription date. *Administrator A stated the emergency kit was used when medication orders were received outside of normal pharmacy business hours. -She gave examples of new medication orders that had been received in the evenings or on the weekends when the facility's normal pharmacy was closed. -If physician's orders were received when their normal pharmacy was closed she would have utilized a medication from the emergency kit to administer the residents' first dose or doses until the pharmacy was able to fill the medication order as prescribed. *She indicated the pharmacy they normally used had given them the emergency kit to use and the prescription medications within it. -After reviewing the contents with her she confirmed there were additional pharmacy's names on the bottles and envelopes of medications.	S 632		

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S 632	Continued From page 44 *She was not aware they should not have had a stock of prescription medications available for residents' use that had not been prepared and specifically labeled for the specific resident. *She was not sure how long they had the emergency kit but thought it had been there for years. Interview on 8/30/23 at 11:45 a.m. with RN B regarding the emergency kit revealed: *She was unsure of the processes for the emergency kit and indicated it had been in place prior to her employment. *She had not seen an emergency kit in the previous assisted living center she worked in. *She thought all residents' physician's orders should have been filled for them by the pharmacy with their specific instructions for use and the prescription date. Phone interview on 8/30/23 at 12:05 p.m. with pharmacist M revealed: *She worked at the provider's contracted pharmacy. -They were the pharmacy that normally supplied all the residents' medications for the facility. *She was aware of the emergency kit of prescription medications that was stocked in the facility. *She thought the assisted living center (ALC) was able to have an emergency kit the same as nursing facilities were able to. -She was not aware ALCs had not had the same rules and requirements for emergency kits of medications as the nursing facilities. *They had provided pharmacy services for other ALCs. -Those ALCs had no emergency kits. *She was aware there was not a licensed nurse working at the facility at all times.	S 632		

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S 632	Continued From page 45 -Administrator A was not a licensed nurse. *She was aware that unlicensed staff were accessing medications from that emergency kit for residents' first doses of medications. *The pharmacy staff had directed administrator A to use medications from the emergency kit if the pharmacy was not open and a new medication order came in for a resident. *She thought the emergency kit had been implemented for the facility four or five years ago. -She stated if the emergency kit was not allowed she would ensure it was removed from the facility soon. Phone interview on 8/30/23 at 2:30 p.m. with consultant pharmacist L regarding the emergency kit revealed: *She had worked with the facility for several years. *Her monthly visits to the facility had been focused on the monthly medication reviews for the residents. *She had known the facility had an emergency kit of prescription medications they used for residents if the pharmacy was not open and an order came in. -That kit had been in place since at least 2019. *She had not seen the facility's emergency kit and had not reviewed what was in it. *She thought that ALCs should not have had an emergency kit. -She had not seen or heard of them in other ALCs she worked with. *She was not aware of the medications that were stored in administrator A's office. *She was aware of the requirement to have specific labeling for the resident, physician, medication name and strength, directions for use, and the prescription date for each resident's medications.	S 632		

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S 632	Continued From page 46 -She confirmed the medications in the emergency kit had not met those labeling requirements. *It was an unsafe practice for prescription medications to have been available and administered by unlicensed staff without the proper labeling of those medications. *There should have been a process in place to obtain a resident's medication from an alternate pharmacy if their pharmacy could not get the medications to the facility.	S 632		
S 642	44:70:07:05 Control and accountability of medications Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure an effective system had been in place for monitoring all controlled medications that were at high risk for diversion or theft and for eight randomly observed residents' (5, 7, 8, 17, 21, 22, 23, and 24) controlled medications. Findings include: 1. Observation, interview, and record review on 8/30/23 at 9:10 a.m. with unlicensed medication aide (UMA) C regarding controlled medications	S 642	Unable to correct prior non-compliance for residents identified. The liquid cough syrups will now be counted with all other controlled medications during the shift change counts. All controlled medications will be counted at shift changes including the liquids and discontinued controlled meds until they are used or destroyed appropriately. All med aides will be educated by the nurse on the processes for controlled medication counting to ensure accountability. All controlled medication count sheets are monitored by the administrator or designee daily. If a controlled medication count is off that will be reported to the nurse and administrator right away for investigation and follow up. The nurse and pharmacist will ensure timely destruction of controlled medications when a medication is discontinued to decrease the risk of potential diversion. The discontinued controlled medications will be counted at shift change until they are destroyed. Results of the monitoring will be reviewed at the monthly leadership meetings.	10/15/23

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S 642	Continued From page 47 revealed: *The UMAs verified the count of every resident's controlled medications between each shift. *Resident 8 had a bottle of liquid promethazine-codeine cough syrup that appeared to have 130 milliliters (ml) of medication left in the bottle. *Review of the Controlled Drug Record sheet for resident 8's cough syrup showed there should have been 170 ml left in the bottle. -There was a discrepancy of approximately 40 ml which would have equaled 10 total doses since it was ordered for 5 ml as needed at bedtime. *Resident 21 had a bottle of liquid promethazine-codeine cough syrup that appeared to have 75 to 80 ml of medication left in the bottle. -Review of the Controlled Drug Record for resident 21's cough syrup showed there should have been 90 ml left. -There was a discrepancy of approximately 10 to 15 ml. --The medication was ordered for 10 ml as needed every six hours. *UMA C confirmed both medications above were not accurate to the count sheet. -She was not sure how long the counts had been off. *She agreed all controlled medications were at risk for potential diversion and should have been closely monitored. -If the amount was not accurate during their counting between shifts they should have notified the nurse or administrator. 2. Interview on 8/30/23 at 9:40 a.m. with registered nurse (RN) B regarding several topics including medication storage and accountability in the facility revealed: *Controlled medications should have been counted by staff each at the change of shift to	S 642		

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S 642	Continued From page 48 ensure the medication counts were accurate. *If the count was off the staff should have notified her or the administrator. *She was not aware of the discrepancies in the above controlled cough syrup medications. *If medications were awaiting destruction they should have been locked and secured until they could have been properly destroyed. *All medications should have been secured from unauthorized individuals. Observation and interview on 8/30/23 at 11:00 a.m. with RN B in administrator A's office to review the medications that were stored in that room revealed: *The office had a lot of miscellaneous items stored all over within the space. *On a cabinet behind the desk there were multiple random resident's medications sitting out in the open. -They were not locked and were not secured. -The door had been open with no one in the office when the RN and surveyor arrived. --Residents had been walking in the hallway outside the office. *RN B indicated the medications appeared to have been for current residents and residents who were no longer residing there. *The random residents' medications were prescription and over-the-counter medications including the following: -Inhaled medications. -Oral medications. -Topical medications. *The medications should not have been stored that way. -They should have been secured from unauthorized individuals at all times and had a process to ensure their accountability.	S 642		

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S 642	Continued From page 49 During the above observation and interview administrator A arrived in her office. Continued interview with RN B and administrator A revealed: *Administrator A confirmed the medications had been left out and were not secured. -She was aware medications should have been secured at all times to ensure security and accountability. *Administrator A had a four-drawer locked file cabinet with additional medications that those medications should have been stored in. *Administrator A retrieved a set of keys from her desk and unlocked the file cabinet. *She opened the third drawer of the file cabinet which included the following: -Multiple prescription and over-the-counter (OTC) medications for multiple residents. -She indicated most were as needed medications for current residents. -Some were medications from residents who no longer resided there and should have been destroyed. *There were two cards of Morphine sulfate (MS) (pain medication) ER 15 milligrams (mg) fourteen tablets and MS ER 30 mg fourteen tablets for resident 22 who was currently in the hospital. -There were no count sheets for those controlled medications. -Administrator A indicated the count sheet would have been started when that medication was put into the medication cart. -There was no monitoring process for those medications in the file cabinet for accountability. *A locked box within that 3rd drawer contained: -Lorazepam (anxiety medication) 0.5 mg six tablets that had expired on 5/9/23 for resident 5. -Clonazepam (anxiety medication) 0.5 mg 10 tablets that had expired on 6/14/23 for resident 17. *RN B left the office during the review of the 3rd	S 642		

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S 642	Continued From page 50 file cabinet drawer. Continued observation and interview with administrator A in her office of the other file cabinet drawers containing medications revealed: *The second drawer of the cabinet was full of random resident's prescription and OTC medications. -Some medications had been expired, some were for current residents, and some were for discharged residents. *A card of Oxycodone 5 mg for discharged resident 7 contained 18 tablets but the Controlled Drug Record sheet with it stated it should have only had 10 tablets left. *The top drawer contained additional controlled medications for discharged residents including the following: -Eszopiclone (sleeping medication) 2 mg six tablets for resident 23. -Tramadol (pain medication) 50 mg ten half tablets for resident 24. *Administrator A confirmed: -There were multiple medications in the file cabinet drawers that should have been destroyed. -The medications in the cabinet had not been monitored and accounted for while awaiting destruction and were being held with medications that were for current residents with current orders. -She had put the medications in the file cabinet and had the keys to access them. *The facility had two RNs and a contracted pharmacist available to help with destruction of medications. -RN B worked in the facility three days a week, the other RN worked as needed, and the contracted pharmacist was in the facility every month.	S 642		

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S 642	Continued From page 51 Interview on 8/30/23 at 11:45 a.m. with RN B regarding the above observations revealed: *She had no idea all those medications were in administrator A's office. *All medications should have been secured and accounted for all times, even when awaiting destruction. *Controlled medications were at a high risk for diversion and should have had a monitoring process in place until they were destroyed. *If there were medications that needed to be destroyed that should have been completed in a more timely manner. *She was unsure why those discharged residents' medications were being held in the office or why she or the pharmacist were not asked to destroy them. Phone interview on 8/30/23 at 2:30 p.m. with consultant pharmacist L regarding medication accountability and security revealed: *She agreed all medications should have been secured and accounted for at all times. *Controlled medications were at risk for potential diversion and should have had count sheets and monitoring of them. *If the count of a controlled medication was not accurate that should have been investigated and followed up on. *She came to the facility every month and asked the staff if any medications needed to have been destroyed. -She had been told there were no medications needing destruction during her recent visits. *Expired medications and medications for discharged residents should have been destroyed soon after their discharge or expiration. *She had never gone into administrator A's office and was not aware of the medications that were stored there.	S 642		

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S 642	Continued From page 52 Review of the provider's revised April 2011 Medication Disposal policy revealed: *Medications should have been disposed of if the following occurred: -The medication was discontinued. -The resident had been discharged or transferred. -The medication was outdated. *"When a resident is discharged or death occurs, the medication disposal sheet is to be retained in the resident's chart." *It had not mentioned a process to ensure accountability or where those medications should have been stored until there were destroyed. Review of the provider's revised 8/11/08 Controlled Drugs policy revealed: *Those types of drugs contained a high potential for abuse. *Any discrepancy should have been reported to the licensed nurse immediately. *Disposal of the drugs should have been done by the licensed nurse and a pharmacist. *There was no information on what should have been done to ensure accountability or where the medications should have been stored until they were destroyed.	S 642		
S 654	44:70:07:06 Drug disposal Any medication held for disposal must be physically separated from the medications being used in the facility and locked with access limited, in an area with a system to reconcile, audit, or monitor them to prevent diversion.	S 654		

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S 654	Continued From page 53 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure accountability of multiple medications waiting for destruction in one of one administrator's office. Findings include: 1. Observation on 8/29/23 at 5:15 p.m. of administrator A's office revealed what appeared to have been medication boxes and bottles sitting on a shelf behind the desk in her office. Administrator A was in her office at that time. Interview on 8/30/23 at 9:40 a.m. with registered nurse (RN) B regarding several topics including medications storage and accountability in the facility revealed: *If medications were awaiting destruction they should have been locked and secured until they could have been properly destroyed. *All medications should have been secured from unauthorized individuals. *When asked about the medications in administrator A's office she had not been aware of them. Observation and interview on 8/30/23 at 11:00 a.m. with RN B in administrator A's office to review the medications that were stored there revealed: *The office had a lot of miscellaneous items stored all over within the space. *On a cabinet behind the desk there were multiple random resident's medications sitting out in the open. -They were not locked and were not secured. -The door had been open with no one in the office when the RN and surveyor arrived. *RN B indicated the medications appeared to	S 654	All medications for residents who were discharged or discontinued/expired medications for current residents have been destroyed by the nurse and pharmacist. Going forward all active residents' medications will be stored securely in the med cart or med room until they are needed for administration. Active meds will be stored separately from meds awaiting destruction. Education for all med aides and nurses will be conducted by the nurse and/or pharmacist regarding the storage and disposal of meds. Monitoring of med storage and med disposal will be done by the nurse or designee twice weekly for a month and then monthly. Results of the monitoring will be brought to the monthly leadership meetings for review.	10/15/23

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S 654	Continued From page 54	S 654		

have been for current residents and residents who were no longer residing there.
*The random residents' medications were prescription and over-the-counter medications including the following:
-Inhaled medications.
-Oral medications.
-Topical medications.
*The medications should not have been stored that way.
-They should have been secured from unauthorized individuals at all times and had a process to ensure their accountability until they had been destroyed or returned to the pharmacy.

During the above observation and interview administrator A arrived in her office. Continued interview with RN B and administrator A revealed:
*Administrator A confirmed the medications had been left out and were not secured.
-She was aware medications should have been secured at all times to ensure security and accountability.
*Administrator A had a four-drawer locked file cabinet with additional medications that those medications should have been stored in.
*Administrator A retrieved a set of keys from her desk and unlocked the file cabinet.
*She opened the third drawer of the file cabinet which included the following:
-Multiple prescription and over-the-counter (OTC) medications for multiple residents.
-She indicated most were as needed medications for current residents.
-Some were medications from residents who were no longer residing there and should have been destroyed.
-There was no monitoring process for those medications in the file cabinet for accountability.
*RN B left the office during the review of the 3rd

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S 654	Continued From page 55 file cabinet drawer. Continued observation and interview with administrator A in her office of the other file cabinet drawers containing medications revealed: *The second drawer of the cabinet was full of random resident's prescription and OTC medications. -Some medications had been expired. -Some were for current residents and some were for residents who were no longer residing there. -There was a card of eighteen Oxycodone (pain medication) 5 mg tablets for discharged resident 7. *The top drawer contained additional medications for discharged residents including the following: -Eszopiclone (sleeping medication) 2 mg six tablets for resident 23. -Tramadol (pain medication) 50 mg ten half tablets for resident 24. *Administrator A confirmed: -There were multiple medications in the file cabinet drawers that should have been destroyed. -Non-controlled medications should have been destroyed by the nurse and a witness. -Controlled medications should have been destroyed by the nurse and pharmacist. -The medications in the cabinet had not been monitored and accounted for while awaiting destruction and were being held with medications that were for current residents and had current orders. -She had put the medications in the file cabinet and had the keys to access them. *The facility had two RNs and a contracted pharmacist available to help with destruction of medications. -RN B worked in the facility three days a week, the other RN worked as needed, and the contracted pharmacist was in the facility every	S 654		

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S 654	Continued From page 56 month. *Medications awaiting destruction should have been destroyed in a timely manner and not kept in the cabinet for several months. Interview with RN B on 8/30/23 at 11:45 a.m. regarding the above observations revealed: *She had no idea all those medications were in administrator A's office. *All medications should have been secured and accounted for all times, even when awaiting destruction. *If there were medications needing to be destroyed that should have been done more timely. *She was unsure why those discharged residents' medications were being held in the office or that she or the pharmacist were not asked to destroy them. Phone interview on 8/30/23 at 2:30 p.m. with consultant pharmacist L regarding medication accountability, security, and disposal revealed: *She agreed all medications should have been secured and accounted for at all times. *She came to the facility every month and asked the staff if any medications needed to have been destroyed. -She had been told there were no medications needing destruction during her recent visits. *Expired medications and medications for residents who were no longer residing there should have been destroyed soon after their discharge. -Discharged residents' medications and expired medications should not have been stored with other residents' active medications. *She had not gone into administrator A's office and was not aware of the medications stored there.	S 654		

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S 654	Continued From page 57 Review of the provider's revised April 2011 Medication Disposal policy revealed: *Medications should have been destroyed if the following occurred: -The medication was discontinued. -The resident had been discharged or transferred. -The medication was outdated. *"When a resident is discharged or death occurs, the medication disposal sheet is to be retained in the resident's chart." *There was no information on a process to ensure accountability or where those medications should have been stored until there were destroyed. Review of the provider's revised 8/11/08 Controlled Drugs policy revealed: *Those types of drugs contained a high potential for abuse. *Any discrepancy should have been reported to the licensed nurse immediately. *Disposal of the drugs should have been done by the licensed nurse and a pharmacist. *There was no information on what should have been done to ensure accountability or where they should have been stored until they were destroyed.	S 654		
S 775	44:70:09:02 Facility to inform resident of rights Prior to or at the time of admission, a facility shall inform the resident, both orally and in writing, of the resident's rights and of the rules governing the resident's conduct and responsibilities while living in the facility. The resident shall acknowledge in writing that the resident received the information. During the resident's stay the	S 775		

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S 775	Continued From page 58 facility shall notify the resident, both orally and in writing, of any changes to the original information. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, agreement review, and policy review, the provider failed to ensure three of six sampled residents (4, 5, and 6) and a randomly interviewed resident (10) had documentation they were provided with resident rights information upon their admission to the facility. Findings include: 1. Review of resident 4's care record revealed: *She was admitted on 10/21/21. *Resident 5 who also lived in the facility was her family and her representative. *There was no documentation she or her representative had been informed of her rights as a resident in the assisted living center (ALC). -The admission paperwork had only been signed by administrator A. 2. Interview on 8/29/23 at 11:05 a.m. with resident 5 in her room revealed: *She had admitted there in the fall of 2021. *She could not remember receiving a copy of her resident rights at the time of her admission or since that time. Review of resident 5's care record revealed: *She was admitted on 10/21/21. *There was no documentation she had been informed of her rights as a resident in the ALC. -The admission paperwork had only been signed by administrator A. 3. Review of resident 6's care record revealed:	S 775	Unable to correct prior non-compliance for residents identified. All residents have now received a copy of their rights and have signed acknowledgement of that. Admission agreements will continue to be done by the administrator during each new resident's admission to the facility. That admission agreement includes a review of the resident rights and acknowledgement they have received that. Administrator has re-read the 44:70 rule regarding resident rights. Nurse will verify completion of the admission agreement and acknowledgement of receipt of resident rights for all new admissions. Results of the monitoring will be reviewed during the monthly leadership meetings.	10/15/23

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S 775	Continued From page 59 *She was admitted on 5/16/23. *There was no documentation she had been informed of her rights as a resident in the ALC. 4. Interview on 8/29/23 at 2:30 p.m. with resident 10 in his room revealed: *He had moved into the ALC in February 2022. *He had not been made aware or given a copy of his rights as a resident in the ALC. Review of resident 10's care record revealed: *He was admitted on 2/28/22. *There was no documentation he had been informed of his rights as a resident in the ALC. -The admission paperwork had only been signed by administrator A. 5. Interview on 8/31/23 at 10:10 a.m. with administrator A regarding the resident admission process revealed: *She was responsible for the admission paperwork for each resident. *She confirmed the resident's rights information was part of the admission process. *The admission paperwork should have been signed by the resident or their representative to acknowledge they had received that information. Review of the provider's undated admission agreement revealed: *A statement at the bottom of the last page: "By this signing this Agreement, I am also stating I received a copy of Assisted Living Center's Bill of Rights." *Areas for signatures on the last page included the facility manager, the resident, and the resident's appointed representative. Review of the provider's undated Admission Agreements policy revealed:	S 775		

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S 775	Continued From page 60 *"Each resident (or responsible party) signs an admission agreement prior to admission." *"2. Prior to admission, the administrator meets with the resident and responsible party to discuss the agreement as well as all fees and the plan of care." *"3. The admission agreement must be signed prior to admission."	S 775		
S 790	44:70:09:03(1-8) Facility to provide information A facility shall provide the following information in writing to each resident: (1) A list of services available in the facility and the charges for those services. The facility shall specify items and services for which the resident may not be charged, those other items and services that the facility offers and for which the resident may be charged, and the amount of any such charges; (2) A description of how a resident may protect personal funds; (3) A list of names, addresses, and telephone numbers of client advocates; (4) A description of how to file a complaint with the department concerning abuse, neglect, and misappropriation of resident property; (5) A description of how the resident can contact the resident's physician, physician assistant, or nurse practitioner, including the name and specialty of the physician; (6) A description of how to apply for and use Medicare and Medicaid benefits, and the right to establish eligibility for Medicaid, including the addresses and telephone numbers of the nearest office of the South Dakota Department of Social Services and of the United States Social Security Administration; (7) A description of the bed-hold policy that	S 790		

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S 790	Continued From page 61 indicates the length of time the bed will be held for the resident, any policies regarding the held bed, and readmission rights of the resident; and (8) A description explaining the responsibilities of the resident and family members regarding self-administered medication. 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 three of six sampled residents (4, 5, and 6) and a randomly interviewed resident (10) had signed admission agreements and acknowledgement of being informed of services available to them. Findings include: 1. Review of resident 4's care record revealed: *She was admitted on 10/21/21. *Resident 5 who also lived in the facility was her family and her representative. *Neither she nor her representative had signed her admission agreement. -The admission agreement had only been signed by administrator A. 2. Interview on 8/29/23 at 11:05 a.m. with resident 5 in her room revealed: *She had admitted there in the fall of 2021. *She could not remember receiving a copy of her admission agreement or signing anything at the time of her admission. Review of resident 5's care record revealed: *She was admitted on 10/21/21. *She had not signed her admission agreement. -The admission agreement had only been signed by administrator A.	S 790	Unable to correct prior non-compliance for residents identified. All residents have now signed copies of their admission agreements. Admission agreements will continue to be done by the administrator during each new resident's admission to the facility. Administrator has re-read the 44:70 rule regarding admission agreements being signed prior to or at the time of their admission. Nurse will verify the admission agreement has been signed by the resident or their representative during her first visit with the resident for all new admissions. Results of the monitoring will be reviewed during the monthly leadership meetings.	10/15/23

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S 790	Continued From page 62 3. Review of resident 6's care record revealed: *She was admitted on 5/16/23. *There was no admission agreement found for her in her care record. 4. Interview on 8/29/23 at 2:30 p.m. with resident 10 in his room revealed: *He had moved into the ALC in February 2022. *He could not remember seeing or signing any admission paperwork when he moved in. Review of resident 10's care record revealed: *He was admitted on 2/28/22. *He had not signed his admission agreement. -The admission agreement had only been signed by administrator A. 5. Interview on 8/31/23 at 10:10 a.m. with administrator A regarding the resident admission process revealed: *She was responsible for the admission paperwork and agreements for each resident. *She confirmed the above residents' admission agreements were not done according to the requirement. *All residents should have had a signed admission agreement in their care records. *The admission agreements should have been signed by the resident or their representative to acknowledge they had received that information. Review of the provider's undated admission agreement revealed areas for signatures on the last page included the facility manager/administrator, the resident, and the resident's appointed representative. Review of the provider's undated Admission Agreements policy revealed: *"Each resident (or responsible party) signs an	S 790		

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S 790	Continued From page 63 admission agreement prior to admission." *"2. Prior to admission, the administrator meets with the resident and responsible party to discuss the agreement as well as all fees and the plan of care." *"3. The admission agreement must be signed prior to admission."	S 790		
S 845	44:70:09:10 Grievances A resident or the resident's designated representative may voice grievances without discrimination or reprisal. A resident's grievance may be given in writing or verbally and may relate to treatment furnished, treatment that has not been furnished, the behavior of other residents, and infringement of the resident's rights. A facility shall adopt a grievance process and make the process known to each resident and to the resident's representative. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and policy review, the provider failed to ensure a documented grievance process was implemented for three of three randomly interviewed and sampled residents (5, 10, and 20) to ensure a resolution had occurred for voiced their grievances. Findings include: 1. Interview on 8/29/23 at 11:05 a.m. with resident 5 in her room revealed: *She had multiple concerns since she moved into the facility in the fall of 2021. *She had brought up her concerns with the facility staff and the administrator and felt they had not followed up with her after she had reported those concerns to them.	S 845	Unable to correct prior non-compliance for residents identified. Going forward all grievances will be documented to include the date, grievance, and response to it. All staff and residents will be educated by the administrator or nurse on the grievance process that concerns can be brought to anyone and then the follow up will be done and documented to support the response occurred. The nurse will will monitor for potential grievances during her weekly assessments for all residents to verify they are documented in the grievance log/binder and followed up on. Results of the monitoring will be reviewed during the monthly leadership meetings.	10/15/23

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S 845	Continued From page 64 *She thought she had items missing from her room such as Christmas decorations, a four-wheeled walker, paperwork, keys to a house, clothing items, and snack items. -She reported that to the staff but no one ever found the items or let her know if anything could have been done about her missing items. 2. Interview on 8/29/23 at 2:30 p.m. with resident 10 in his room revealed: *He had concerns at times with how things were handled in the facility. *He felt the staff made up "rules on the fly." *When he brought up concerns to staff or the administrator hewould not get any answers or a response. -He would have liked to have a reason or response to know they took his concerns seriously. *He had no idea if there was a grievance process that should have been completed. 3. Interview on 8/29/23 at 4:30 p.m. with resident 20 in her room revealed: *She had lived there for several years. *She had reported concerns to the staff at times and had not felt they followed up on them. *She had reported to several staff members about one worker who was not speaking nicely or respectfully to some of the confused residents. *She was upset because she felt the administration and staff had not dealt with it and that the staff member continued to speak in not a nice manner to those residents. *Her call pendant had not worked, staff had taken it, and they had not replaced it. *She was told by staff she could use her cell phone to call them for help. *She wanted a call pendant but had given up on asking about it.	S 845		

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	41884	A. BUILDING: _____ B. WING _____	C 08/31/2023

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S 845	Continued From page 65 4. Interview on 8/29/23 at 4:45 with unlicensed medication aide (UMA) D regarding residents' concerns or grievances revealed: *Staff would have tried to help with the concern and fix it right away if they could. *They would have reported a resident's concerns to administrator A to follow up on if the concern was something more serious. Interview on 8/30/23 at 10:00 a.m. with registered nurse B regarding residents' concerns or grievances revealed: *If a resident informed her about a concern she would have tried to assist with it if she could. *If the concern was something serious or she could not have addressed it right away she would have reported it to administrator A to have followed up on. *She was not sure if there was a formal process for documenting and resolving grievances. -She would have documented it in her nurse's notes if it was relevant to their care. Interview on 8/30/23 at 12:40 p.m. with UMA C regarding residents' concerns or grievances revealed: *Residents reported concerns to her at times. *She would try to address their concern if she could. *If the concern was something she could not fix she would have reported it to administrator A. Interview on 8/31/23 at 10:10 a.m. with administrator A regarding the grievance process for the facility revealed: *They had no documented grievances or any record of grievances that had been received from residents or others. *Most grievances were reported to her and she	S 845		

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S 845	Continued From page 66 would just take care of them. *She was not aware of any current resident grievances. *She agreed if there was no documentation it was difficult to support what her or other staff had done to resolve the resident's grievances or concerns. Review of the provider's undated Complaints policy revealed: *"Each resident has the personal right to be informed by the administrator (or a designated representative) of provisions of law regarding complaints and of procedures to confidentially register complaints, including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency." *At the time of admission the following should have occurred: -The resident was informed of the complaint policy. -The resident was informed of the facility's desire to accommodate resident requests, needs, complaints, and concerns. -The resident was informed of the process for registering complaints. *"5. Caregivers bring all resident requests, concerns, and/or complaints to the attention of his/her immediate supervisor or the administrator." *"6. The administrator (or designated representative) investigates all complaints and discusses his/her findings with the resident and his/her responsible party." *The policy had not indicated the process for documentation of those complaints.	S 845		

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{S 000}	Compliance Statement An onsite revisit survey was conducted from 10/30/23 through 10/31/23 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 8/31/23. Elder Inn was found not in compliance with the following requirements: S125, S131, S156, S167, S215, S275, S280, S296, S375, S838, and S845.	{S 000}		
{S 125}	44:70:02:08 Linen The facility shall have distinct areas for the storage and handling of clean and soiled linens. Those areas used for the storage and handling of soiled linens must be negatively pressurized. The facility shall establish special procedures for the handling and processing of contaminated linens. Soiled linen must be placed in closed containers prior to transportation. To safeguard clean linens from cross contamination, they must be transported in containers used exclusively for clean linens must be kept covered with dust covers at all times while in transit or in hallways, and must be stored in areas designated exclusively for this purpose. Written requests for any modification of the requirements of this section shall be reviewed and approved by the department before any changes are made. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, observation, and review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the provider failed to ensure: *The policy for contaminated laundry included specific processing information. *All staff were educated regarding handling and processing of linens that included the policies.	{S 125}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy L Meyer — TITLE: Administrator — (X6) DATE: 12/03/23

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{S 125}	Continued From page 1 *Policies were posted and available to the staff for review in the laundry room. Findings include: 1. Interview on 10/30/23 at 3:15 p.m. with unlicensed medication aide J revealed: *She did not recall having any recent training on laundry handling or processing since the 8/31/23 survey. *Night shift staff and administrator A completed most of the laundry processing. *Day and evening shift staff collected residents' and facility dirty laundry daily. *Evening shift staff delivered the clean laundry back to the residents' rooms. *She was aware of concerns with bed bugs in different residents' rooms in recent months. -If she was informed of a potential bed bug infestation in a room she would strip the resident's bedding, put it into a bag, and take the contaminated laundry to the laundry room. *She thought administrator A or the night shift staff would then process that laundry separately but she was not sure of the process for that particular contaminated laundry. Observation on 10/31/23 at 8:00 a.m. in the laundry room revealed there was no evidence of instructions or policies for staff to reference for the process of handling and/or processing contaminated laundry or laundry that had potential or actual bed bug infestation. Interview and review of the POC on 10/31/23 at 11:30 a.m. with administrator A revealed: *There was no documentation to support all staff had received education as written in the POC. *She was responsible for ensuring the education in the POC occurred. -She had verbally educated staff but there was no	{S 125}	Each resident's laundry will be gathered on a specific day/days and will be laundered separately. A schedule of when each resident's laundry is to be picked up from their room will posted. Each resident will have their own laundry receptacle with a bag in it. When their laundry is picked the bag will be tied and marked with their room # on it. When their laundry needs to be picked up on a different day; as if it is badly soiled or contaminated it will be tied up and marked soiled and or contaminated and handled according to our posted laundry instructions. All staff of the 3 shifts will be informed of the process and it will be documented. All facility towels and bedding will be laundered separately in hot water. This will be monitored daily by the Administrator for 2 weeks to get the routine down and then weekly times 1 month. An audit report for this will be compiled in a binder and will be reported monthly at the QA meeting. An instruction sheet on the laundry process for the resident's personal clothes will be posted in the laundry room along with how they should be washed in the machine and the drying process for the dryer. An instruction process sheet will be posted in the laundry room on how to handle contaminated laundry and will be posted in the laundry room for the staff to follow. This will be gone over with all staff and documented. Monthly audits will continue until QA committee determines audits can be discontinued.	12/15/23

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{S 125}	Continued From page 2 documentation to support that education. *The policy on contaminated laundry did not have specific information on how it should have been processed other than laundering it separately. *They were still commingling all residents' laundry and using the same process for laundry prior to the 8/31/23 survey. *Contaminated laundry from a resident's room with potential or confirmed bed bugs was laundered the same as all other laundry, it was just completed in a separate load. *She agreed if the laundry processing had not been effective at eradicating the bed bugs then that laundry would have been commingled and potentially used in other residents' rooms. *The POC indicated the policies for contaminated laundry and laundry with bed bugs should have been posted in the laundry room for staff to reference. *She was responsible for the implementation of the POC. -The POC had not been followed. Refer to S156.	{S 125}		
{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 policies and procedures for the handling and storage of potentially hazardous substances (including lab specimens). This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and review of the plan of correction (POC) from the 8/31/23 licensure and	{S 131}		

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{S 131}	Continued From page 3 complaint survey with a completion date of 10/15/23, the provider failed to ensure all staff were educated regarding: *Using separate rags for each resident's room during cleaning and disinfection. *Using the facility's cleaners and disinfectants according to the manufacturer's instructions. *Following the instruction sheets for housekeeping. Findings include: 1. Interview on 10/30/23 at 3:15 p.m. with unlicensed medication aide J revealed she did not recall having any recent training since the 8/31/23 survey. Interview and review of the POC on 10/31/23 at 11:30 a.m. with administrator A revealed: *There was no documentation to support all staff received education as indicated above. *She was responsible for ensuring the education specified in the POC occurred. *She had verbally educated staff, but there was no documentation to support that education. *She was responsible for the implementation of the POC. -The POC had not been followed.	{S 131}	All staff of the 3 shifts will be informed of the cleaning instructions,will be informed specifically of using a clean separate rag/rags for each room. They will each be given a copy of the cleaning instruction sheet and it will be documented and each staff will sign the documentation sheet. A copy of the cleaning instructions will be placed in a binder and a binder will be placed on each of the 3 cleaning carts. This will be monitored daily by the Administrator for 2 weeks and then weekly for 1 month. Monthly audits will continue until QA committee determines audits can be discontinued. An audit report for this will be compiled in a binder and will be reported at the monthly QA meeting.	12/15/23
{S 156}	44:70:02:15 Insect and Rodent Control The facility shall take effective measures to protect against the entrance into the facility and the breeding or presence on the premises of rodents, flies, roaches, and other vermin. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, policy review, and review of the plan of correction (POC) from	{S 156}		

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{S 156}	Continued From page 4 the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the provider failed to ensure processes were implemented to effectively eradicate the bed bugs. POC items had not been fully implemented for the following areas: *Policies for bed bugs were developed and implemented in accordance with Department of Health (DOH) or Centers for Disease Control (CDC) guidelines. *All staff education regarding: -Policies for suspicion of bed bugs and the notifications, responses, and follow-up that should have occurred related to them. -Their role in observing for signs of bed bugs during daily tasks and the follow-up that should have occurred. *Zippered covers were not used for three of four randomly reviewed residents' beds (10, 16, and 20). *Documentation had not supported the notification to a pest control company for suspicions of bed bugs. *Leadership meetings had not occurred to review trends of the bed bugs or if current interventions were working. *Audits of the facility's bed bug documentation and responses had not been completed. *Thirteen residents (2, 5, 6, 10, 13, 14, 16, 17, 19, 20, 27, 28, and 29) had reported concerns with bed bugs in their rooms and in the facility. -The facility had a total of thirty-seven residents at the time of the survey. Findings include: 1. Observation and interview on 10/30/23 at 2:23 p.m. with resident 6 in her room revealed: *She was resting in her recliner with a blanket over her. *She indicated it was okay for the surveyor to look	{S 156}		

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{S 156}	Continued From page 5 at her bed for potential bed bugs. *She had white sheets under the comforter. -The fitted white sheet had several brownish colored spots noted near the head of the bed on the left side. *There was a mattress pad under the fitted sheet and zippered plastic covers were on the mattress and box spring. *When pulling the mattress pad and fitted sheet back into place a small, approximately sesame seed-sized, live bed bug was found crawling on top of the fitted sheet under a pillow. *She thought the bed bugs had been taken care of but had seen them in the past. -She had not noticed any bug bites on her skin lately but had bug bites in the past. 2. Observation and interview on 10/30/23 at 2:42 p.m. with resident 10 in his room revealed: *He had bed bugs in his room in the past. -He was unsure when he had last seen a bed bug on his bed. *He was familiar with bed bugs and knew what to look for. *He had heard there were bed bugs found in several rooms in the building and thought the staff were working on that. *His top mattress had a zippered plastic cover on it but the box spring had not had one. -The box spring had a manufacturer's plastic covering on it that had been cut and was opened on the foot end of the bed. 3. Interview on 10/30/23 at 3:15 p.m. with unlicensed medication aide J regarding education since the 8/31/23 survey revealed: *She could not recall having any recent training regarding bed bugs. *If she heard of a bed bug or saw one she would have let administrator A know about it.	{S 156}	A comprehensive plan is being written for prompt detection, responses and interventions in regards to the bed bug issues that have appeared. Administrator has been in contact with the pest control company on reporting any issues and how to handle each situation that may arise. A comprehensive evaluation by the pest control company along with a representative from DOH will take place on 11/28/23. Administrator will be contacting DOH to discuss scheduling training on bed bug detection for staff. All residents mattresses and box springs have protective zippered coverings on. Laundry process is being changed to do each residents laundry separately. Every Wednesday and Thursday when Housekeeper (F) works the Administrator and Housekeeper (F) check all rooms for any suspicion of bed bugs. Monitoring of this will be done on those two days weekly for one month and then twice monthly for one month and then monthly by the Administrator. Audits will be done and discussed at the monthly QA meetings. Staff will report to Administrator or Nurse any bed bugs seen or suspected. This will be logged in a binder to identify room or location, date, response and followup. Administrator will be in contact with Pest Control Company on 12/04/23 to set a date to be scheduled for them to come again for staff education on bedbugs. Owner will be informed of the date to be here. Bedbug policy is written and all staff will be educated. Laundry instructions are written for handling of resident's laundry who have been identified with bed bugs. All staff will be educated on this process. Audits for this will continue until QA committee determines they can be discontinued.	12/15/23

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{S 156}	Continued From page 6 *If a bed bug was found in a resident's room staff would have put those bed linens into a bag and brought them to the laundry room. *After that she was unsure what other processes for bed bugs should have been completed. *She thought administrator A handled the bed bug follow-up. 4. Observation and interview on 10/30/23 at 4:10 p.m. with resident 20 in her room revealed: *She had recently found bugs in her bed and in her bathroom. -She believed they were bed bugs. *She had reported the bed bugs to staff and thought the staff had "fumigated" her room, but she had found more bed bugs after that. *She thought an "exterminator" had been at the facility in three different residents' rooms. -She was not aware that if the pest control company had been in her room. *The last time she had seen a bed bug was about three weeks ago. -She had found it in her pajamas when she woke up in the morning. -She had told the nurse and administrator, but had not seen any follow-up since then. *She had bed bug bites on her neck and her feet in the past but had not noticed any recent bites. *She had her own queen-sized bed. -No zippered plastic covers were in place to either the mattress or the box spring on her bed. *She reported other residents having issues with bed bugs too and expressed frustration that the bed bugs continued to be a concern in the building. 5. Observation and interview on 10/30/23 at 4:45 p.m. with resident 16 in her room revealed: *She had concerns with bed bugs in her room over the past several months.	{S 156}		

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{S 156}	Continued From page 7 *There was a light-colored powder on the floor near the head of her bed for approximately a four foot span along the wall. -She indicated staff put that powder on the floor to kill bed bugs. *There were no zippered plastic covers on her mattress or box spring. *She felt staff were working on getting rid of the bed bugs, but they continued to be a problem. *A pest control company had sprayed her room for bed bugs a few times that she was aware of. -Administrator A had sprayed for bed bugs as well. *Staff had been washing her bed linens and vacuuming her room more often. *When she made her bed every day she checked her bedding for brownish or blood colored spots and bed bugs. -She had only ever found evidence of bugs in her bed, she had not found them anywhere else in her room. *She had two different types of topical itch treatments in her room due to her problems with bed bug bites. -She used hydrocortisone cream or Aquafor itch cream. *She stated that the bug bites occurred on places where her skin was exposed when she slept. -Usually the bites were on her face, neck, and feet. *She expressed frustration that the bed bugs continued to be a problem. *She felt embarrassed that bed bugs had been found in her room. *She thought she was the only one having problems with bed bugs until recently when she heard from other residents who had them in their rooms too. *She reported not sleeping well at times due to her fear of further bed bug bites and bed bugs in	{S 156}		

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{S 156}	Continued From page 8 her bed. *Her hope was that the bed bugs would be taken care of for her and all other residents as soon as possible. 6. Interview on 10/30/23 at 5:17 p.m. with caregiver N revealed: *She had worked for the facility for nine years. *A few months ago she started working on the evening shift. -She had worked on the night shift prior to that. *When working on the night shift she had worked in laundry and the kitchen areas primarily. *She could not recall having any recent training or bed bug training. *She was unsure what was happening related to bed bugs in the facility. 7. Interview on 10/30/23 at 5:35 p.m. with two anonymous residents revealed: *One resident did not have a bed, they had a reclining lift chair they slept in. *A resident reported concerns with bed bugs being found in the facility in other residents' rooms. -They were not aware of any bed bugs in their rooms, but one of them thought they had seen one on their shoe recently. 8. Interview on 10/31/23 at 8:50 a.m. with registered nurse B revealed: *She felt they were still identifying and having issues with bed bugs in the facility and in the residents' rooms. -She was not highly involved in the processes for bed bugs. *She had attended the pest control company's training a few weeks ago and felt it was helpful information. -Not all staff were in attendance for that training.	{S 156}		

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{S 156}	Continued From page 9 *She was unsure what training on bed bugs had occurred for all staff other than the pest control company's visit. *Administrator A and housekeeper F were the staff that primarily dealt with bed bugs in the facility. *As the nurse she saw all the residents at a minimum of weekly. *If a resident reported a concern with bed bugs to her she would let administrator A know about it. -After that administrator A handled the response to the resident's report of bed bugs. *She indicated the pest control company had told them normal laundry processes or chemicals would not kill bed bugs. -They were told to use high temperatures to kill the bed bugs when doing laundry. *She was unsure if there had been any changes in the laundry processes in relation to the bed bugs since the 8/31/23 survey. *She was not sure if administrator A notified the pest control company every time a suspicion or actual bed bug was identified in the facility. -She thought the pest control company had been there recently. *Administrator A handled the notifications to the pest control company and documentation of those visits. *She was not sure if residents and their representatives were notified when bed bugs were suspected or found in their rooms. -She felt they should have been notified about that as well as what response was happening for them. *She agreed bed bugs were a concern in the facility and it was affecting the residents. -She mentioned the following residents reporting or having concerns with bed bugs recently: --Residents 6, 10, 16, 17, and 27.	{S 156}		

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{S 156}	Continued From page 10 9. Review of the provider's undated Bed Bug policy revealed: *"When or if a resident or employee suspects findings of bed bugs they should contact the Administrator or Nurse as soon as possible. The Nurse or Administrator will access [assess] the situation and get in contact with the pest control company for recommendations on how to proceed. The resident will be informed of how the situation is going to be handled." -That was the entire policy. *The policy had not addressed the following: -Notifications to resident representatives. -Processes that should have been implemented or initiated in response to the bed bugs such as laundry, garbage, cleaning, or other items. -Any evidence that DOH or CDC guidelines had been reviewed and incorporated into the policy. -What documentation should have been completed related to the bed bugs. -A comprehensive plan to address and eradicate the pest control concern of bed bugs. Review of the provider's undated Contaminated Laundry Handling and Processing policy revealed: *"When a resident has contaminated laundry or soiled, place it in a white garbage bag and mark it with the appropriate Room # and it will be cleaned separately. Pest Control company said to launder it separately and most importantly is drying it on high heat." -That was the entire policy. *It had not mentioned: -How long to dry the laundry on high heat. -Instructions for staff on how to set the dryer to ensure that high heat level was met. Review of the provider's undated Bed Bug Policy for Laundry revealed:	{S 156}		

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{S 156}	Continued From page 11 *"Roll the laundry into a bundle and put it in a garbage bag and tie the bag tight. That bag of laundry will be laundered separately and dried on high heat. If it includes personal laundry also be sure it is marked with the resident's room #." -That was the entire policy. *It had not mentioned: -How long to dry the laundry on high heat. -Instructions for staff on how to set the dryer to ensure the high heat level was met. -If it included only the bed linens that were found to have bed bugs or all laundry in that resident's room. 10. Review of the 10/12/23 pest control invoice revealed: *Service description was "Staff Education" with a note of: -"Spoke with [administrator A] and staff on bedbug life stages and early detection/monitoring. Also able to show them contained bedbugs and spotting." -It had not mentioned processes for the eradication of bed bugs. *A handwritten note by administrator A stated the inservice was held on 10/11/23 and the staff present included administrator A, nurse B, housekeeper F, unlicensed medication aide (UMA) C, UMA D, and caregiver O. -That was not the entire staff. 11. Review of the 10/13/23 laundry service report had no mention of bed bugs being discussed, process changes for laundry, water temperatures of the washer, or anything related to high temperatures for drying laundry. 12. Review of the provider's Documentation Log for Suspicion or Actual Findings of Bed Bugs revealed:	{S 156}		

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{S 156}	Continued From page 12 *On 10/19/23 there were four entries listed as being reported by the nurse that included: -Resident 2 had seen a bed bug in her room. --Action was administrator A and housekeeper F vacuumed everything, bedding was done, and nothing was found. --Follow-up had dates of 10/20/23, 10/21/23, and 10/22/23 with "ok" written in. -Resident 13 said he found some bed bugs on his chair. --Action was to vacuum his chair and washed his chair cover. --Follow up on 10/20/23, 10/21/23, and 10/22/23 was vacuuming every day and changing chair cover. -Resident 16 said she found a bed bug on her bed. --Action was housekeeping washed all bedding and "was her room cleaning day." --Follow up was "nothing since" on 10/20/23, 10/21/23, and 10/22/23. -Resident 28 reported seeing two bed bugs on his chair. --Action was vacuumed chair, wiped it down, and clean cover put on. --Follow up had dates of 10/20/23, 10/21/23, and 10/22/23 with no mention of what specifically was done. *On 10/24/23 under room it stated "pest control company in town." -Action was "Had them spray" and listed the following residents' rooms: --Resident 2's chair and bed --Resident 13's chair. --Resident 14's chair. --Resident 17's chair. --Resident 19's chair. --Resident 28's chair and bed. --Resident 29's chair. -Follow up was "pest control company will come	{S 156}		

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{S 156}	Continued From page 13 back week of 10/30/23." --It had not indicated what other responses or monitoring was occurring. *There was no evidence of pest control company notification on 10/19/23 for the four resident's concerns. *The 10/24/23 pest control company visit notes: -Had not identified if they evaluated or sprayed in relation to resident 16's report on 10/19/23. -Had included spraying for residents 14, 17, 19, and 29. --Those residents had not been mentioned in previous documentation to support when bed bugs had been found or what other responses occurred. *The documentation log had not included: -Residents 6 and 20 who reported bed bug concerns during interviews and observations on 10/30/23. -All residents the nurse reported to have recent bed bug concerns during her interview on 10/31/23. --She had also mentioned residents 6, 10, and 27. *There was no sufficient evidence to support effective processes were being implemented to eradicate the bed bugs that were being reported or that were suspected in multiple areas of the building. 13. Interview, policy review, and review of the POC on 10/31/23 at 11:30 a.m. with administrator A revealed: *She confirmed the policies above were the policies that were developed after the 8/31/23 survey. *She confirmed the policies had not addressed: -Notifications to resident representatives. -Specific processes that should have been implemented or initiated in response to the bed	{S 156}		

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{S 156}	Continued From page 14	{S 156}		

bugs for laundry, garbage, cleaning, or other items.
-Instructions for staff to follow for bed bugs.
-Any evidence that DOH or CDC guidelines had been reviewed and incorporated into the policy.
-What documentation should have occurred related to the bed bugs.
-A comprehensive plan to address and eradicate the pest control concern of the bed bugs.
*There was no documentation to support that all staff had received education as indicated in the POC.
-She confirmed only a small group of staff had been educated by the pest control company.
*She was responsible for ensuring the education specified in the POC occurred.
-She had verbally educated staff but there was no documentation to support that education.
*She thought they were doing better with the bed bugs in the facility but confirmed there were still reports of them being identified.
*Audits related to this citation for bed bugs had not been completed.
*Monthly leadership meetings had not occurred to review trends and current interventions for bed bugs.
*She confirmed the documentation log for bed bugs had missing information.
-It had not listed all efforts that were being implemented including when she was notifying the pest control company of new suspicions of bed beds.
*She agreed the documentation log had not matched all residents' reports to ensure appropriate responses were occurring.
*She confirmed bed bugs were a pest control concern and affected the residents' overall health and well-being.
*She was responsible for the overall daily operations and management of the facility which

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{S 156}	Continued From page 15 included ensuring the POC was being followed. -She confirmed the POC had not been followed. Refer to S125, S280, and S375.	{S 156}		
{S 167}	44:70:02:17(3) Occupant protection The facility shall take at least the following precautions: (3) Provide an emergency staff call system for resident use to summon assistance from staff. The system must be capable of being easily activated by a resident and must register both visually and audibly at the staff station. The system must be utilized and maintained in a manner to ensure it is a consistent and effective means for a resident to alert staff of the need for assistance. The call system must also meet at least one of the following requirements: (a) The call system utilizes fixed call stations convenient for resident use and activated by a pull cord or other approved device. The fixed call stations must be located at each bed, toilet, and bathing facility used by a resident. (b) The call system is a wireless system with devices carried by a resident; or (c) The call system is another type of call system that has been submitted for review and approved by the department; A call station or device is not required in the resident room of a cognitively impaired resident if a nursing assessment determined the resident would not benefit from the availability. This Administrative Rule of South Dakota is not	{S 167}		

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{S 167}	Continued From page 16 met as evidenced by: Based on interview and review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the provider failed to ensure all staff were educated regarding the residents' call pendant availability and system. Findings include: 1. Interview on 10/30/23 at 3:15 p.m. with unlicensed medication aide J regarding education since the 8/31/23 survey revealed: *She could not recall having any recent training regarding the call pendants. *She thought all residents but three residents with cognitive impairment had a call pendant. *If there was a problem with a call pendant she would let administrator A know. Interview and review of the POC on 10/31/23 at 11:30 a.m. with administrator A revealed: *There was no documentation to support all staff had received education as indicated above. *She was responsible for ensuring the education specified in the POC occurred. -She had verbally educated staff but there was no documentation to support that education. *She was responsible for the implementation of the POC. -The POC had not been followed.	{S 167}	All staff of the 3 shifts have been educated regarding the residents call pendants. A pendant was shown to all staff and explained how to reset it. A photo printout of the pendant and instruction sheet on how it works was given to each staff member and each staff signed the documentation sheet. This will be monitored by the Administrator upon each new hire. This will be reported at the monthly QA.	11/24/23
{S 215}	44:70:03:03 Fire extinguisher equipment Fire extinguisher equipment shall be installed and maintained by to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must	{S 215}		

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{S 215}	Continued From page 17 be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the plan of correction (POC) from the 8/31/23 survey that had a completion date of 10/15/23, observation, and interview, the provider failed to ensure monthly maintenance checks were completed for four of eight fire extinguishers. Findings include: 1. Review of the POC from the 8/31/23 survey that had a completion date of 10/15/23 revealed administrator A was responsible for completing the monthly maintenance checks for the fire extinguishers by the 15th of each month. Observation on 10/31/23 at 8:15 a.m. revealed the fire extinguishers in the kitchen and northeast corridors of the building indicated there were no monthly maintenance checks written on the fire extinguisher tags for the month of October. Interview on 10/31/23 at 11:50 a.m. with administrator A revealed she: *Was responsible for completing those monthly maintenance checks for the fire extinguishers. *Had it written down on her calendar to complete on the 15th of each month. *Stated she must have missed a few of them. *Agreed the POC had not been followed.	{S 215}	All fire extinguishers have been checked and dated by 10/31/23 and have been checked and dated for the month of November. This will be done the first Tuesday of each month and will be monitored by housekeeper F and reported to the Administrator. An audit report will be completed and reported at monthly QA. Housekeeper F will check this on the first Wednesday of the month when Emergency Lights are checked.	11/24/23

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S 275	44:70:04:01 Governing body Each facility operated by limited liability partnership, a corporation, or political 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 interview, record review, and review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the governing body failed to ensure compliance with the Administrative Rules of South Dakota 44:70 Assisted Living Center regulations related to the following areas of concern: *Education was not completed according to the POC for all staff for all the areas of identified deficient practice. *New policies had not been written and implemented according to the POC. *Multiple residents continued to have concerns with bed bug infestations in their rooms and in the building. *Random residents reported verbal abuse from staff when they requested assistance and a fear of staff retaliation when they reported any concerns to staff or others. Findings include: 1. Observations, interviews, POC review, and record reviews during the onsite revisit survey on 10/30/23 from 1:55 p.m. through 6:00 p.m. and on 10/31/23 from 7:30 a.m. through 12:30 p.m. revealed:	S 275	Education will be documented and signed by all staff for the additional training that has been done. Pest control concerns are being addressed as they arise. On site visit with the pest consultant company scheduled 11/28/23. Residents quality of life concerns are being addressed. The State Ombudsman doing an inservice at the facility on 12/12/23. QA meeting was held with Administrator, nursing, staff on 11/14/23. QA meeting will be held on the 4th Tuesday of each month to include Administration, Nursing, and Owners. This will be coordinated by Nurse B and will be monitored monthly by the Administrator. An audit report for this will be compiled, placed in the audit binder and reported monthly at the QA meeting. The owner is always available by phone and lives here in town and can always stop by when needed. The facility's overall practices will be discussed at the monthly QA meetings and the compliance with the survey will be reviewed with the owner at the monthly QA committee meetings.	12/15/23

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S 275	Continued From page 19 *The POC had not been fully implemented for multiple areas of deficient practice identified during the 8/31/23 survey. *Education had not been documented to support all staff had received additional training according to the POC. *Pest control concerns with bed bugs remained a concern for multiple residents in the building and the POC for that had not been fully implemented. *An additional area of concern for resident's quality of life was cited as a deficient practice for potential verbal and mental abuse. Interview on 10/31/23 at 11:30 a.m. with administrator A revealed: *The owners of the facility were not involved in the daily operations. -She was able to communicate with them via the phone any time. -One of the owners had stopped by the facility occasionally but not on a regular basis or any specific schedule. *The owners were aware of the recent survey. *She was responsible for the overall facility operation including ensuring the residents' care and quality of life had been maintained. *She was responsible for ensuring the POC was implemented for the recently conducted licensure and complaint survey. *She confirmed the POC had not been followed for all previous areas of deficient practice. *They had never had any quality meetings regarding the facility operations. *They had not had any quality meetings with herself, the nurses, and owners as she had not gotten that scheduled yet. *She was supposed to set up monthly quality meetings as written in the POC. *She should have scheduled those quality meetings to ensure the owner was able to	S 275		

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S 275	Continued From page 20 participate. Refer to S125, S131, S156, S167, S215, S280, S296, S375, S838, and S845.	S 275		
{S 280}	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the governing body failed to support and ensure the administrator managed the facility in a manner that ensured the daily overall management, resident care, and resident quality of life was in compliance with the Administrative Rules of South Dakota 44:70 Assisted Living Center regulations related to the following areas of concern: *Education was not completed according to the POC for all staff for all areas of identified deficient practice. *New policies had not been written and implemented according to the POC. *Multiple residents continued to have concerns with bed bug infestations in their rooms and in the building. *Random residents reported verbal abuse from	{S 280}		

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{S 280}	Continued From page 21 staff when they requested assistance and a fear of staff retaliation when they reported any concerns to staff or others. Findings include: 1. Observations, interviews, POC review, and record reviews during the onsite revisit survey on 10/30/23 from 1:55 p.m. through 6:00 p.m. and on 10/31/23 from 7:30 a.m. through 12:30 p.m. revealed: *The POC had not been fully implemented for multiple areas of identified deficient practice from the 8/31/23 survey. *Education had not been documented to support all staff had received additional training according to the POC. *Pest control of bed bugs remained a concern for multiple residents in the building and the POC for that deficiency had not been fully implemented. *An additional area of concern for resident's quality of life was cited as an identified deficient practice for potential verbal and mental abuse. Interview on 10/31/23 at 11:30 a.m. with administrator A revealed: *The owners were not involved in the daily operations of the facility. *She was responsible for the overall facility operations including ensuring the residents' care and quality of life had been maintained. *She was responsible for ensuring the POC had been implemented for the recent licensure and complaint survey. *She confirmed the POC had not been followed for all previous areas of deficient practice. *They had never had quality meetings for the facility. *They had not had any quality meetings with herself, the nurses, and owners as she had not gotten that scheduled yet.	{S 280}	POC will be implemented for the areas of identified deficient practices. Education will be documented for training, pest control concerns are being addressed and coordinated with the Pest Control Company. Quality of life concerns for residents are being addressed with an inservice scheduled for 12/12/23. QA meeting was completed on 11/14/23 and QA meetings will be held every 4th Tuesday; being coordinated by Nurse B and will include Adminstrator, Nursing, and Owners. This will be monitored monthly by the Administrator. Audit report will be in the audit binder and checked monthly. At the monthly QA meetings Administrator and Nurse will review all citations to insure the POC is fully implemented	12/15/23

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{S 280}	Continued From page 22 *She was supposed to set up monthly quality meetings as written in the POC. Refer to S125, S131, S156, S167, S215, S275, S296, S375, S838, and S845.	{S 280}		
{S 296}	44:70:04:04 Personnel training Ongoing education programs must cover the required subjects annually. These programs must be completed within 30 days of hire for all healthcare employees and must include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (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, neglect, and misappropriation of resident property and funds; (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 employee education necessary based on the individualized resident care needs provided by the healthcare	{S 296}		

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	41884	A. BUILDING: _____ B. WING _____	R 10/31/2023

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{S 296}	Continued From page 23 employees to the residents who are accepted and retained in the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the provider failed to ensure all staff were educated regarding the fire drill process to ensure residents' safety. Findings include: 1. Interview on 10/30/23 at 3:15 p.m. with unlicensed medication aide J regarding education since the 8/31/23 survey revealed: *She could not recall having any recent training on fire drills. *There was a fire drill during the 8/31/23 survey and she thought the fire alarm sounded accidentally recently but she could not recall any additional training on fire drills. Interview and review of the POC on 10/31/23 at 11:30 a.m. with administrator A revealed: *There was no documentation to support all staff had received education as indicated in the POC. *She was responsible for ensuring the education specified in the POC occurred. -She had verbally educated staff but there was no documentation to support that education. *She was responsible for the implementation of the POC. -The POC had not been followed.	{S 296}	All staff of the 3 scheduled shifts will be educated on the details of a fire drill process and what to do when or if the fire alarms go off. This will be documented on the fire drill instruction sheet and signed by each staff. This will be monitored upon each new hire by the Administrator and documented. A monthly audit will be done and reported at QA meeting.	12/15/23
S 375	44:70:04:15 Quality assessment Each facility shall provide for on-going evaluation of the quality of services provided to residents.	S 375		

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S 375	Continued From page 24 Components of the quality assessment evaluation shall include establishment of facility standards; review of resident services to identify deviations from the standards and actions taken to correct deviations; resident satisfaction surveys; utilization of services provided; and documentation of the evaluation and report to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey, interview, and record review, the provider failed to provide documentation they had completed the corrections identified on their POC related to quality assurance (QA) meetings and POC items to achieve compliance. Findings include: 1. Review of the provider's 8/31/23 complaint survey POC with a completion date of 10/15/23 for S280 revealed: "Administrator has read the 44:70 rules and the areas of deficient practice. Administrator will ensure the POC for all tags is being followed and will ensure documentation to support the POC is being done. The administrator will implement a new quality meeting with the nurses and owner to discuss systems and monitoring for areas of deficient practice and quality of care and services within the facility. These leadership meetings will be monthly with the possibility of changing to quarterly in the future." During the entrance conference on 10/30/23 at 1:55 p.m. with administrator A all POC items were requested from the 8/31/23 complaint survey. Those items included the following: *All documentation of staff meetings or individual staff education completed related to the POC.	S 375	A QA meeting was held on November 14 that included Adminstrator, Nursing, Staffing, and Owners. QA meetings will be coordinated by Nurse B and will be held every 4th Tuesday. This will be monitored by the Administrator and recorded monthly on a audit report. Nurse will review all tags that have been cited in survey, will go over any staff concerns, residents concerns that have come up. Nurse will record notes of the meetings, topics discussed and attendance will be recorded.	11/25/23

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S 375	Continued From page 25 *Proof of audits and monitoring completed as indicated in the POC. *QA meeting or other meeting notes to support the POC items were being completed and reviewed. *All reviewed, revised, or created policies according to the POC. *All forms, checklists, or other documents revised or created according to the POC. Interview, record review, and POC review on 10/31/23 at 11:30 a.m. with administrator A regarding the 8/31/22 survey education, audits, QA meetings, and documentation supporting the POC had been followed revealed: *She was responsible to ensure completion of the POC. *She confirmed the documentation and revisit information had not supported the POC had been followed for all previous areas of identified deficient practice. *They had not had any quality meetings with herself, the nurses, and owners as she had not gotten that scheduled yet. *She confirmed the POC had not been followed. Refer to S125, S131, S156, S167, S215, S275, S280, S296, S838, and S845.	S 375		
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.	S 838		

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S 838	Continued From page 26 This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, policy review, and resident rights review, the provider failed to ensure residents were free from potential verbal and mental abuse. Anonymously interviewed residents reported verbal abuse from staff when they requested assistance and a fear of staff retaliation when they reported any concerns to staff or others. Findings include: 1. Random anonymous resident interviews on 10/30/23 and 10/31/23 during the survey revealed the following concerns: *They wanted to remain anonymous because they feared retaliation from the staff if they shared their concerns with the surveyor. *In the past they had been "scolded" or "reprimanded" when they reported any concerns they had in the facility. -Because of that they did not feel safe to report their concerns. *They reported feeling verbally and mentally abused by the staff's words, tone of voice, and body language shown to them. -The staff had used harsh, demeaning, or disrespectful comments related to their requests or need for assistance, financial statuses, and other areas. *They had been told not to use their call pendants to ask for staff assistance unless it was an emergency. -When or if they used the call pendant they felt staff got angry that they had to answer it or assist them. -Based on the way the staff responded or reacted they did not feel safe to use their call pendant. Interview on 10/31/23 at 11:30 a.m. with	S 838		

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S 838	Continued From page 27 administrator A revealed: *She was aware of the residents' right to be free from verbal or mental abuse and their right to voice concerns or grievances without fear of retaliation. *She agreed all staff members should have treated residents respectfully and courteously. *Certain tones of voice, body language, and word choices could have been perceived by the residents as harsh, demeaning, or disrespectful. *She agreed staff should have been mindful of their actions and responses to the residents at all times. Review of the October 2019 Resident Rights brochure provided to residents in the facility revealed: *"You have the right to be free of interference, coercion, discrimination, and reprisal from the ALC when exercising your rights." *The facility must provide care and an environment that contributed to quality of life including: -"1. A safe, clean, comfortable and homey environment." -"4. Freedom from theft of personal property; verbal, sexual, physical or mental abuse; and involuntary seclusion, neglect or exploitation imposed by anyone." *"You or your representative may voice grievances without discrimination or reprisal. The grievance may be provided verbally or in writing and may relate to treatment furnished, treatment not furnished, the behavior of other individuals living in the ALC or infringement of your rights." Review of the provider's undated Abuse, Fraud, and Wrongdoing policy revealed: *"Residents, their responsible parties, personnel, health professionals and all relevant stakeholders	S 838	An inservice is scheduled on December 12th for the State Ombudsman to come to the facility. This will be monitored by the Administrator and staff will sign acknowledging their attendance at the meeting. This will be reported at monthly QA meetings. The topics of resident rights, abuse and retaliation will be covered. All staff have been informed of the meeting and encouraged them to make every effort to attend. Staff that are not able to attend will be given handouts and the State Ombudsman will have information for them to review. The Nurse will monitor resident treatment by staff and grievances and retaliation during her weekly assessments for each resident. This will be reviewed at monthly QA .	12/15/23

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S 838	Continued From page 28 may report such activities, policies or practices without fear of restraint, interference, coercion, discrimination or reprisal..." *"Residents, their responsible parties, personnel, health professionals and all relevant stakeholders are encouraged to report any suspected incidence of abuse, fraud, or other wrongdoing."	S 838		
{S 845}	44:70:09:10 Grievances {S 845} A resident or the resident's designated representative may voice grievances without discrimination or reprisal. A resident's grievance may be given in writing or verbally and may relate to treatment furnished, treatment that has not been furnished, the behavior of other residents, and infringement of the resident's rights. A facility shall adopt a grievance process and make the process known to each resident and to the resident's representative. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, policy review, and review of the plan of correction (POC) from the 8/31/23 licensure and complaint survey with a completion date of 10/15/23, the provider failed to ensure all staff and residents were educated regarding the grievance process to ensure concerns could be brought to anyone with documentation of that grievance and the follow up that was completed. Findings include: 1. Interview on 10/30/23 at 3:15 p.m. with unlicensed medication aide J regarding education since the 8/31/23 survey revealed: *She could not recall having any recent training regarding grievances.		All staff will be instructed of the grievance process and documentation. This will be documented by all staff also. When a resident has a complaint, request, need or concern the Administrator will address the issue and discuss it with the resident or their responsible party. This will be audited and reported at QA meeting. Nurse will monitor resident grievances at their weekly assessment visit.	12/15/23

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{S 845}	Continued From page 29 *If she heard a grievance she would let administrator A know. Review of the provider's undated Complaints policy revealed: *"Each resident has the personal right to be informed by the administrator (or a designated representative) of provisions of law regarding complaints and of procedures to confidentially register complaints, including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency." *At the time of admission the following should have occurred: -The resident was informed of the complaint policy. -The resident was informed of the facility's desire to accommodate resident requests, needs, complaints, and concerns. -The resident was informed of the process for registering complaints. *"5. Caregivers bring all resident requests, concerns, and/or complaints to the attention of his/her immediate supervisor or the administrator." *"6. The administrator (or designated representative) investigates all complaints and discusses his/her findings with the resident and his/her responsible party." *The policy had not indicated the process for documentation of those complaints. Interview and review of the POC on 10/31/23 at 11:30 a.m. with administrator A revealed: *There was no documentation to support all staff and residents received education as indicated above. *She was responsible for ensuring the education specified in the POC occurred. -She had verbally educated staff but there was no	{S 845}		

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{S 845}	Continued From page 30 documentation to support that education. *She was responsible for the implementation of the POC. -The POC had not been followed.	{S 845}		

South Dakota Department of Health

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{S 000}	Compliance Statement A second onsite 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 1/17/24, for all previous deficiencies cited on 10/31/23. All deficiencies have been corrected, and no new noncompliance was found. Elder Inn was found in compliance with all regulations surveyed.	{S 000}		

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