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
	41812	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW ASSISTED LIVING	410 S BROADWAY ST POST OFFICE BOX 247 BRYANT, SD 57221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/18/25 through 11/19/25. Parkview Assisted Living was found not in compliance with the following requirements: S115, S201, S450, S642, and S654.	S 000	Kitchen Handwashing sink 1. The clogged kitchen, handwashing sink was fixed by a plumber on Nov 24th, 25, to ensure proper drainage. 2. A back up plan has been implemented; if the sink becomes non-operational, staff must immediately notify the administrator and use the kitchen sink equipped with hand soap and single-use towels until the repairs are complete. 3. The administrator will do weekly checks on the handwashing sink in the kitchen x4 weeks, and monthly for 6 months, and then after that time she will decide if they need to continue monthly checks or that they haven't been having any issues and can be discontinued.	12/3/25
S 115	44:70:02:07 Handwashing Facilities Handwashing facilities consisting of hot and cold running water dispensed through a mixing faucet controlled with blade handles or other hands-free controls, a towel dispenser with single-service towels or a hand-drying device, and hand cleanser must be located in dietary areas, utility rooms, staff stations, physical therapy rooms, laundry rooms, and all toilet rooms. A handwashing facility must be provided in each resident room or in a bath or toilet room connected directly to the room. If existing faucets and controls are replaced or changed, they must be replaced with mixing faucets controlled with blade handles or other hands-free controls. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that the handwashing sink was operational and single-service towels and hand cleaner were available in one of one kitchen and one of one laundry room. Findings include: 1. Observation and interview on 11/18/25 at 11:30	S 115		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin Johnson | TITLE: LPN/Administrator | (X6) DATE: 12/8/2025

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S 115	Continued From page 1 a.m. with certified medication aide (CMA) C in the kitchen revealed: *The hand-washing sink had approximately four inches of dirty water in it that would not drain. *She used the two-compartment sink to wash her hands with dish soap and dried her hands on a cloth towel that was on the counter next to the sink before preparing the residents' lunch. *She was unsure how long the handwashing sink had been clogged and not draining, but thought it had been "a few days." *She thought administrator/licensed practical nurse (LPN) A and maintenance director B were aware that the sink was not working because it had been an ongoing problem, and she had notified administrator/LPN A "a few days ago." 2. Observation and interview on 11/18/25 at 11:58 a.m. and again on 11/19/25 at 8:50 a.m. with administrator/LPN A regarding the kitchen handwashing sink revealed: *Administrator/LPN A and maintenance director B were aware that the handwashing sink contained dirty water that would not drain. *Maintenance director B had fixed the sink drain, but it had stopped draining again. *Administrator/LPN A expected the staff members to use the two-compartment sink to wash their hands until the sink was repaired. *She was unaware that staff members did not have single-use towels or hand soap available at the two-compartment sink for washing and drying their hands. 3. Observation and interview on 11/19/25 at 8:35 a.m. with CMA C in the laundry room revealed: *A utility sink with a small hose attached to the faucet. *The single-use paper towel dispenser was empty.	S 115	Laundry Room Handwashing Facilities 1. the hose was taken off the sink in the laundry room on the 21st of Nov by the owner, soap and paper towels were stocked by the sink. The sink can be used to wash soiled hands if need be. 2. Staff is aware that they have to keep it stocked as they do in any other location in the building as it runs out. 3. Alcohol-based hand sanitizer was placed in the laundry room on 11-21-25 as additional infection control measure. 4. All staff were re-educated by the admin on the hand-hygiene policy in the in-service on 11-21-25 emphasizing: a. requirement to use soap and single-use paper towels b. to report sinks that don't work properly to admin and if the dispensers are empty to fill them immediately. 5. The administrator will do weekly audits ensuring that there is soap, paper towels, and hand sanitizer available in the laundry room and that the sink is functioning correctly, weekly x4 weeks, and then monthly for 6 months. And if sustained compliance is complete they will no longer have to be audited. Administrator will ensure that staff continues to receive annual refresher training on hand hygiene and infection control.	12/3/25

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S 115	Continued From page 2 *The soap dispenser was empty. *She used that sink to clean items and did not use it for hand washing. *No hand sanitizer was available in the laundry room. *She would use the sink in the bathroom located across the hallway from the nurses' station when she needed to wash her hands. 4. Observation and Interview on 11/19/25 at 10:05 a.m. with administrator/LPN A in the laundry room revealed she: *Confirmed that the utility sink could not be used for handwashing because the faucet had a hose attached to it. *Confirmed that single-use paper towels and hand soap dispensers were empty. *Expected staff to wear gloves when they completed laundry and to use hand sanitizer before putting on gloves and after removing their gloves. *Confirmed there was no hand sanitizer in the laundry room. *Expected staff members to use the sink in the bathroom located across the hallway from the nurses' station when they needed to wash their hands. 5. Review of the provider's updated 12/4/23 Hand Hygiene Policy revealed: *"Handwashing and/or using 60% [percent]alcohol-based hand sanitizer are the most effective techniques for preventing the spread of infection." *"Equipment: 1. Sink with running water 2.Antiseptic soap 3. Paper towels."	S 115		
S 201	44:70:03:02 General Fire Safety	S 201		

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S 201	Continued From page 3 Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation, testing, and interview the provider failed to maintain operational battery pack emergency lighting for two of seven locations (front door and east wing). Findings include: 1. Observation and testing on 11/19/25 at 11:19 a.m. revealed the battery pack emergency light at the front door did not operate on the battery backup when that circuit was tested. Interview with the Administrator A at the same time as the observation confirmed that condition. When asked if she had documentation of the testing required for emergency lights, she stated she knew she was supposed to test the exit signs but did not know the battery pack emergency lights had the same requirements for testing and she did not have any documentation that they had been tested. 2. Observation and testing on 11/19/25 at 11:47 a.m. revealed the battery pack emergency light in the east corridor did not operate on the battery backup when that circuit was tested. Interview with the Administrator A at the same	S 201	General Fire Safety 1. For both of non-operational batter pack emergency lights (front door and east wing), the batteries have been replaced and are working correctly. 2. Administrator will do monthly checks to make sure that they are all working properly. Sprinkler Clearance 1. The administrator will put on monthly audits to make sure nothing is 18 in around any sprinkler heads in the facility. 2. Staff was made aware of this regulation on 11-21-25 in the in-service by the administrator.	12/6/25 11/21/25

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S 201	Continued From page 4 time as the observation confirmed that condition. When asked if she had documentation of the testing required for emergency lights, she stated she knew she was supposed to test the exit signs but did not know the battery pack emergency lights had the same requirements for testing and she did not have any documentation that they had been tested. B. Based on observation, and interview, the provider failed to maintain the required unobstructed space of at least 18 inches around a sprinkler deflector at one randomly observed location (storage room). Findings include: 1. Observation on 4/15/25 at 11:02 a.m. revealed the sprinkler head in the storage room was obstructed by two boxes of gowns on top of a storage cabinet. The boxes of gowns were placed directly next to the sprinkler head deflector. The location of those items would interrupt the proper discharge and operation of the sprinkler head. Interview with the Administrator A at the time of the observation revealed she was not aware of the obstructed sprinkler head in that location. She further stated if she had noticed those boxes that close to the sprinkler head, she would have moved them immediately.	S 201		
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06.	S 450		

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S 450	Continued From page 5 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to prevent foodborne illness risks in one of one kitchen to: *Ensure proper hand hygiene by one of one certified medication assistant CMA (C) during meal service preparation and serving. *Ensure temperature probe cleaning by one of one CMA C during the preparation of one of one observed meal service. Findings include: 1. Observation and interview on 11/18/25 at 11:30 a.m. with CMA C in the kitchen revealed: *The hand-washing sink had approximately four inches of dirty water in it that would not drain. *She used the two-compartment sink to wash her hands with dish soap and dried her hands on a cloth towel that was on the counter next to the sink before preparing the residents' lunch. *She was unsure how long the handwashing sink had been clogged and not draining, but thought it had been "a few days." *CMA C took a thermometer out of a basket to the left of the stove and, without cleaning the thermometer probe, she checked the temperature of the two pizzas she was preparing. *After checking the temperatures without cleaning the thermometer probe, she placed the thermometer back in the basket. *Without washing her hands, CMA C then took two slices of bread out of a bag and placed them in the toaster, took a knife from a drawer, opened the margarine, and then removed the toast from the toaster. Using one hand to hold the toast, she spread butter on each slice and cut the toast in	S 450	Dietetic Services 1. The handwashing sink in the kitchen was repaired by a plumber on the 24th of November. 2. A policy was made for cleaning the thermometer probes and the staff has all been made aware of this in the in-service on the 21st of Nov, by the administrator. Staff is to clean the thermometer probe before and after each use with an alcohol swab that is located in the same place as the thermometer. 3. Staff was also retrained on proper hand hygiene and glove use during the meal preparation, during the in-service on 11-21-25 by the administrator. 4. The administrator will do weekly audits on the staff preparing the meal and the ones serving it for 1 month, and monthly for 6 months, and if compliance is sufficient audits can cease. The dietician will continue to do her yearly in-services on safe food handling, and she will also do 6 months audits of the kitchen. 5. Policies revised on preventing contamination by employees, policy for preventing contamination from equipment, utensils, and wiping cloths, and another on handwashing and glove use for meal preparation.	12/3/25

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S 450	Continued From page 6 half. That toast was served to resident 1 and resident 2. *Then without washing her hands, CMA C placed the pizza, salad, and beverage containers on a cart and served pizza to six residents in the dining room. CMA C used her ungloved hands and a knife to cut pieces of pizza and alternated between using a pair of tongs and her ungloved hands to place pizza from the cart onto the residents' plates. 2. Observation and interview on 11/19/25 at 8:48 a.m. with CMA C in the kitchen revealed: *The hand-washing sink had approximately four inches of dirty water in it that would not drain. *CMA C used the two-compartment sink to wash her hands with dish soap and dried her hands on a cloth towel that was on the counter next to the sink before preparing the residents' breakfast. *CMA C confirmed that she had not cleaned the thermometer probe before or after checking the temperature of the pizza on 11/18/25. She knew where the cleaning wipes were, but she had forgotten to use them. *CMA C stated that washing her hands while preparing meals was more difficult because the handwashing sink was broken. She used the hand soap and paper towels when washing her hands at the handwashing sink, but had not realized that she was using dish soap and a cloth towel on the counter to dry her hands when using the two-compartment sink. *She confirmed that she had not washed her hands or worn gloves before touching the ready-to-eat toast and pizza, and was unsure when she needed to wear gloves when preparing resident foods. 3. Observation and interview on 11/19/25 at 8:50 a.m. with administrator/licensed practical nurse	S 450		

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S 450	Continued From page 7 (LPN) A regarding the kitchen handwashing sink revealed: *Administrator/LPN A confirmed that the kitchen handwashing sink had not been repaired since they discovered it was broken a couple of weeks ago. *Administrator/LPN A expected the staff members to use the two-compartment sink to wash their hands during meal preparation until the sink was repaired. *She was unaware that staff members did not have single-use towels or hand soap available at the two-compartment sink for washing and drying their hands. *Administrator/LPN A expected that staff members preparing resident food would wash their hands when beginning the meal preparation, when their hands were dirty, before putting on gloves, and after removing gloves. *She expected that staff members would wear gloves when preparing residents' ready-to-eat foods like pizza and toast. *She expected that the thermometer probe would be cleaned before checking the temperature of the resident's food and after each use. 4. Interview on 11/19/25 at 12:01 p.m. with registered dietitian (RD) E, who participated by phone, revealed: *RD E was unaware that the provider's handwashing sink was broken. *She expected staff members to wash their hands when entering the kitchen, between food service tasks, when their hands were soiled, before putting on gloves, and after removing gloves. *She expected staff members to wear gloves when preparing residents' ready-to-eat foods if they were unable to use tongs or other utensils. *Hand sanitizer was not a replacement for	S 450		

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S 450	Continued From page 8 handwashing and could be used while serving residents' food, but not while preparing those foods in the kitchen. *She confirmed that the food thermometer probe should be cleaned and sanitized with an alcohol wipe before use, between resident foods, and after temping the foods. 5. Review of the provider's undated Handwashing & Hand Sanitizer Policy for Meal Preparation policy revealed: *"Purpose to ensure proper hand hygiene is maintained during meal preparation to prevent contamination of food and reduce the spread of infection." *"Hand Hygiene Expectations During Meal Prep" -"Before beginning any food preparation" -"Between handling different types of food (raw to ready-to-eat) -"After handling dirty dishes or utensils" *"Approved Methods of Hand Hygiene" -"Handwashing with soap and warm water for at least 20 seconds." -"70% [percent] alcohol-based hand sanitizer may be used ONLY when hands are not visibly soiled and when staff are not handling raw meats." *"Glove Use" -"Gloves do not replace hand washing. Perform hand hygiene before putting on gloves and after removing them. Change gloves between tasks and whenever contaminated."	S 450		
S 642	44:70:07:05 Control And Accountability of Medications The facility must receive written authorization from the resident's physician, physician assistant, or nurse practitioner before releasing any medication to a resident upon discharge, transfer,	S 642		

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S 642	Continued From page 9 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, record review, and policy review, the provider failed to ensure an effective system had been in place for security, storage, accountability, and timely destruction of controlled medications (medications with risk of abuse, addiction, and potential theft) in one of one medication cart. Findings include: 1. Observation and interview on 11/18/25 at 2:15 p.m. with certified medication aide (CMA C) and administrator/licensed practical nurse (LPN) A of the medication cart revealed: *The medication cart contained a locked box within the cart that contained controlled medications. That locked box contained: -Resident 3's "Lorazepam TAB [tablet] 0.5MG [milligram]" medication bubble pack card with a prescription number 7410031, dispensed from the pharmacy on 10/11/24, with an expiration date of 10/9/25. A dose had been administered on 4/20/25 and again on 10/3/25 for a total of two medication doses. --The three-ring binder with the shift counting record and Controlled Drug Receipt/Record/Disposition count sheet indicated that resident 3's as-needed Lorazepam TAB	S 642	Control and Accountability for Medications 1. All expired controlled medications were removed from the cart and destroyed per policy with the RN witness on the 20th of Nov. 2. Controlled medications will be in a locked box attached inside the locked filing cabinet, by Dec 12th. 3. Medication cart policy was revised and reviewed by the staff ensuring that the med cart is locked at all times when unattended, this one was done on the 3rd of Dec. 4. Medication Aides were trained by the administrator and the RN on controlled medication handling procedures on the 21st of Nov at the in-service. 5. Administration delegated night shift to do monthly audits of the med cart to ensure all outdated medications are being removed in a timely manner and that med cart is clean and in order. The RN will then do monthly audits, indefinitely to ensure that this is being done correctly.	12/12/25

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S 642	Continued From page 10 0.5MG was for prescription number 7087683 and had been dispensed from the pharmacy on 7/3/24. --The prescription number and delivery dates did not match. --CMA C and administrator A were unaware that resident 3's Lorazepam bubble pack prescription number and pharmacy dispense date did not match the count sheet, and that the medication had expired on 10/9/25. ---Administrator/LPN A removed that expired medication from the locked box and the Controlled Drug Receipt/Record/Disposition count sheet and placed a rubber band around the medication bubble pack and Controlled Drug Receipt/Record/Disposition count sheet and placed it back in the locked box and stated she would destroy that medication with registered nurse (RN) D when she came to the facility. -Resident 4's as-needed "Lorazepam TAB 0.5MG *SPARE DOSE* (1/2 [half] TAB)," dispensed from the pharmacy on 7/14/25 in a small plastic bag, was in the bottom of that locked box. --The three-ring binder with the shift counting record and Controlled Drug Receipt/Record/Disposition records did not contain a count sheet for resident 4's as-needed "Lorazepam TAB 0.5MG *SPARE DOSE* (1/2 TAB)" medication. --CMA C and administrator/LPN A were unaware that resident 4 had been dispensed a spare dose of Lorazepam from the pharmacy and that that medication was in the bottom of the locked box. --Administrator/LPN A confirmed there was no Controlled Drug Receipt/Record/Disposition count sheet for resident 4's "Lorazepam TAB 0.5MG *SPARE DOSE* (1/2 [half] TAB)" medication. *The shift counting record and Controlled Drug Receipt/Record/Disposition binder contained a Controlled Drug Receipt/Record/Disposition count	S 642		

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S 642	Continued From page 11 sheet for resident 5's as-needed "Alprazolam 0.5MG." -That medication bubble pack was not located in the locked box and was found stored in the next drawer with resident 5's scheduled medications. --Administrator/LPN A indicated that resident 5's as-needed "Alprazolam 0.5MG," should have been stored in the locked box within the cart that contained controlled medications. ---The count sheet matched the number of doses that had been administered. 2. Observation on 11/19/25, starting at 7:56 a.m. in the main living area near the nurses' station, revealed: *At 7:56 a.m., the medication cart that contained all of the residents' medications was between the dining and living room and was unlocked. -Resident 2 was seated in the living area, and no staff were present. *At 8:23 a.m. CMA C entered the living area with a resident's laundry and proceeded to the laundry room. The medication cart remained unlocked. *At 8:50 a.m. CMA C entered the kitchen to prepare a resident's breakfast. The medication cart remained unlocked. *At 9:15 a.m., the medication cart was locked. *Administrator/LPN A stated that she had entered the facility at 9:00 a.m. and found the medication cart unlocked and had locked the medication cart. *CMA C had been unaware that she had left the medication cart unlocked. 3. Interview on 11/19/25 at 2:02 p.m. with pharmacy consultant F, who participated by phone, revealed: *He confirmed that resident 3's as-needed Lorazepam TAB 0.5MG medication bubble packs had been delivered to the facility from the pharmacy on 7/3/24 and again on 10/11/25 with	S 642		

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	41812	A. BUILDING: _____ B. WING _____	11/19/2025

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S 642	Continued From page 12 Controlled Drug Receipt/Record/Disposition count sheets. -He became aware that the facility had a discrepancy with those Controlled Drug Receipt/Record/Disposition count sheets, and that administrator /LPN A had been unable to locate a destruction record or the medication when administrator/LPN A had contacted him on 11/18/25. *The medication bubble packs for as-needed doses of Lorazepam should have been stored in the locked box within the medication cart and not with the residents' scheduled medications. *All controlled medications delivered from the pharmacy, including a "spare dose," would be delivered to the facility from the pharmacy with a Controlled Drug Receipt/Record/Disposition count sheet. The facility staff would count that dose until it was administered or destroyed. The facility retains the medication count and destruction records. *He expected that the facility would maintain an accurate count of controlled medications and retain a record of controlled medication destruction. *Resident medications awaiting destruction needed to be stored separately from current resident medications. 4. Interview on 11/19/25 at 3:10 p.m. with administrator/LPN A and RN D revealed: *The CMA staff often received medication from the pharmacy, ensured the count was correct, and placed the medication in the medication cart. *As-needed controlled medications were placed in the locked box within the medication cart, and the count sheet was placed in the binder. *Controlled medications awaiting destruction were kept with the corresponding Controlled Drug Receipt/Record/Disposition count sheet, in the	S 642		

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S 642	Continued From page 13 locked box within the medication cart with the other controlled medications until RN D was at the facility and available to destroy them with administrator/LPN A. *Administrator/LPN A was unaware that controlled medications awaiting destruction needed to be accounted for and stored separately from the current medication supply. 5. Interview and review of resident 3's Lorazepam TAB 0.5MG medication bubble packs Controlled Drug Receipt/Record/Disposition count sheet on 11/19/25 at 3:38 p.m. with administrator/LPN A and RN D revealed: *Resident 3's as-needed Lorazepam TAB 0.5MG medication bubble pack with prescription number 7087683 that had been dispensed from the pharmacy on 7/3/24, had been found in a locked filing cabinet at the nurse's station with the Controlled Drug Receipt/Record/Disposition count sheet for the Lorazepam TAB 0.5MG, with a prescription number 7410031, that had been dispensed from the pharmacy on 10/11/24. *They were unsure who had placed that medication and the Controlled Drug Receipt/Record/Disposition count sheet in that filing cabinet drawer or how long it had been there. *Six doses of that Lorazepam TAB 0.5MG, with a prescription number 7410031, medication had been administered, and six doses had been recorded as administered on the Controlled Drug Receipt/Record/Disposition count sheet for the Lorazepam TAB 0.5MG, with a prescription number 7087683. -The prescription numbers and the dates the medication was dispensed from the pharmacy did not match. *Administrator/LPN A expected that the Controlled Drug Receipt/Record/Disposition count	S 642		

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S 642	Continued From page 14 sheets and the medication bubble pack prescription numbers would have matched when they were in the medication cart and when they were removed from the medication cart and awaiting destruction. *RN D had not worked at the facility in 2024 and would not have been the registered nurse responsible for the destruction of medications at that time. *Medications that were not controlled substances were stored in the locked filing cabinet at the nurse's station, awaiting destruction. She expected controlled medications, such as Lorazepam, to remain in the locked box of the medication cart, accompanied by the corresponding Controlled Drug Receipt/Record/Disposition count sheets attached with a rubber band. *RN D and administrator/LPN A agreed that the current medication storage system did not ensure controlled medications were stored safely and remained accounted for while awaiting destruction. 6. Interview on 11/19/25 at 4:09 p.m. with director of pharmacy G, who participated by phone, revealed: *A spare dose of resident 4's Lorazepam TAB 0.5MG had been delivered to the facility on 7/14/25, after a facility staff member had called the pharmacy to report that they had given resident 4 an as-needed dose of her Lorazepam out of the medication bubble pack of her scheduled Lorazepam. *The spare dose of Lorazepam had a separate Controlled Drug Receipt/Record/Disposition count sheet, and he expected that the spare dose would have been the next dose of that medication provided to resident 4. *He expected that the spare dose of Lorazepam	S 642		

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S 642	Continued From page 15 would have been counted with other controlled medications at shift changes until it had been used or destroyed. 7. Review of the provider's undated Controlled Medication Count Policy and Procedure revealed: *"To ensure accurate and compliant management of controlled medications." *"Procedure 1. Count meds [medications] at each shift change- both staff [members] ongoing and oncoming. 2. Store in a double locked storage. 3. Document all administration immediately. 4. Report discrepancies immediately to administration." 5. Maintain records for 2 [two] years."	S 642	Drug Disposal 1. All expired controlled medication were removed from the cart and destroyed per policy with the RN witness on the 20th of N 2. Controlled medications will be in a locked box inside a locked filing cabinet, by Dec 12 3. Medication cart policy revised and review by the staff ensuring that the med cart is locked at all times when unattended, this w done on the 3rd of Dec. 4. Medication aides were trained by the administrator and the RN on controlled medication handling procedures on the 21s Nov at the in-service. 5. Administration delegated night shift to d monthly audits on the med cart to ensure a outdated medications are being removed ir timely manner and that the med cart is clea and in order. The RN will then do monthly audits, indefinitely to ensure that this is beir done correctly.	12/12/25
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. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to have a secure system for storing and accounting medications that were awaiting destruction in one of one filing cabinet. Findings include: 1. Observation and interview on 11/18/25 at 2:15 p.m. with certified medication aide (CMA C) and administrator/licensed practical nurse (LPN) A of	S 654		

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S 654	Continued From page 16 the medication cart revealed: *The medication cart contained a locked box within the cart that contained controlled medications. That locked box contained: -Resident 3's "Lorazepam TAB [tablet] 0.5MG [milligram]" medication bubble pack card with a prescription number 7410031 that expired on 10/9/25. --Administrator/LPN A removed that expired medication from the locked drawer and the Controlled Drug Receipt/Record/Disposition count sheet and placed a rubber band around the medication bubble pack and Controlled Drug Receipt/Record/Disposition count sheet and placed it back in the locked drawer and stated she would destroy that medication with registered nurse (RN) D when she came to the facility. 2. Interview and review of resident 3's Lorazepam TAB 0.5MG medication bubble packs and Controlled Drug Receipt/Record/Disposition count sheets on 11/19/25 at 3:38 p.m. with administrator/LPN A and RN D revealed: *Resident 3's as-needed Lorazepam TAB 0.5MG medication bubble pack with prescription number 7087683 had been found in a locked filing cabinet at the nurse's station. *They were unsure who had placed that medication in that filing cabinet drawer or how long it had been there. *Medications that were not controlled substances were stored in the locked filing cabinet at the nurse's station, awaiting destruction. *She expected controlled medications, like Lorazepam, to have remained in the locked box in the medication cart with the corresponding Controlled Drug Receipt/Record/Disposition count sheets attached to it with a rubber band until the RN and LPN were able to destroy them. *Administrator/LPN A was unaware that controlled	S 654		

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S 654	Continued From page 17 medications awaiting destruction needed to be accounted for and stored separately from the current medication supply. *RN D had not worked at the facility in 2024 and would not have been the registered nurse responsible for the destruction of medications at that time. *She agreed that their current system did not ensure controlled medications were stored safely and remained accounted for while awaiting destruction. 3. Review of the provider's undated Controlled Medication Count Policy and Procedure revealed: *"To ensure accurate and compliant management of controlled medications." *"Procedure 1. Count meds [medications] at each shift change- both staff [members] ongoing and oncoming. 2. Store in a double locked storage. 3. Document all administration immediately. 4. Report discrepancies immediately to [the] administration. 5. Maintain records for 2 [two] years."	S 654		