

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47881	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER PONDEROSA LODGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 S LOUISE AVE SIOUX FALLS, SD 57108		
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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 on from 11/12/25 through 11/13/25. Ponderosa Lodge Senior Living was found not in compliance with the following requirements: S200, S201, S215, S296, S305, S352, and S485.	S 000		
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing and interview, the facility failed to maintain the fire resistive rating of three randomly observed fire walls (south wing fire wall, south wing north stairs, and south wing separation from garage). Findings Include: 1. Observation, testing, and interview on 11/13/25 at 10:23 a.m. revealed the 90-minute fire-rated door on the first floor in the fire wall separating the main entrance area from the south wing would not close and latch on three of three	S 200	Corrected 11/15/25 Doors will no longer be propped open to adhere to Fire safety code requirements 44:70.03.01 MD will repair doors that did not latch by 12/15/25 Maintenance Director or designee will round on this M-F X4 weeks and then Monthly until Compliance is Achieved. MD or designee will be responsible for compliance. This will be reviewed at monthly safety meeting until compliance is achieved	12/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Martina Castle

TITLE Executive Director

(X6) DATE
12/8/25

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S 200	<p>Continued From page 1</p> <p>attempts. The door's externally mounted latch had become ajar such that the striker could not latch into it.</p> <p>Interview with maintenance director H at the same time as the observation and testing confirmed those conditions. When asked if he had documentation of the annual testing required for fire doors, he stated he was unaware of that requirement.</p> <p>2. Observation, testing, and interview on 11/13/25 at 10:53 a.m. revealed the 60-minute fire-rated door on the first floor in the south wing north stairwell would not close and latch on three of three attempts. Further observation at that same time revealed the externally mounted door latch had been removed.</p> <p>Interview with maintenance director H at the same time as the observation and testing confirmed those conditions. When asked if he had documentation of the annual testing required for fire doors, he stated he was unaware of that requirement.</p> <p>3. Observation, testing, and interview on 11/13/25 at 12:14 p.m. revealed the 90-minute fire-rated door on the first floor in the south wing north stairwell to the garage would not close and latch on three of three attempts. That door would close under the power of the automatic door closer, but the striker did not latch into the door frame.</p> <p>Interview with maintenance director H at the same time as the observation and testing confirmed those conditions. When asked if he had documentation of the annual testing required for fire doors, he stated he was unaware of that requirement.</p>	S 200		

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S 201 S 201	<p>Continued From page 2</p> <p>44:70:03:02 General Fire Safety</p> <p>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.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by:</p> <p>A. Based on observation, testing, and interview, the provider failed to maintain continuous illumination for one randomly observed exit sign (south wing west exit).</p> <p>Findings include:</p> <p>1. Observation, testing, and interview on 11/13/25 at 10:39 a.m. revealed the exit sign for first exit of the west stair did not operate on the battery backup when that circuit was tested. Interview with maintenance director H at the same time as the observation confirmed that condition. When asked if he had documentation of the testing required for exit signs, he stated he usually tests the exit signs randomly and while he tests them monthly, he did not have records of performing them.</p> <p>B. Based on observation, testing, interview, and record review the provider failed to maintain operational battery pack emergency lighting for five randomly observed locations (emergency lights 10, 5, and 4).</p>	S 201 S 201	<p>Light was fixed on 12/5/25 Maintenance Director or Designee Monthly review of exit signs and emergency Light battery pack until compliance is achieved.</p> <p>MD will test all exit lights monthly and will document in tels. This will be reviewed monthly at our safety meeting until compliance is achieved.</p> <p>MD or designee is responsible for this task.</p>	12/5/25

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S 201	<p>Continued From page 3</p> <p>Findings include:</p> <p>1. Observation and testing on 11/13/25 at 11:14 a.m. revealed the battery pack emergency light marked number ten did not operate on the battery backup when that circuit was tested. Interview with maintenance director H at the same time as the observation confirmed that condition. When asked if he had documentation of the testing required for emergency lights, he stated he usually tests the emergency lights randomly and while he tests them monthly, he did not have records of performing them. Record review that same day confirmed that finding.</p> <p>2. Observation and testing on 11/13/25 at 11:48 a.m. revealed the battery pack emergency light marked number five did not operate on the battery backup when that circuit was tested. Interview with maintenance director H at the same time as the observation confirmed that condition. When asked if he had documentation of the testing required for emergency lights, he stated he usually tests the emergency lights randomly and while he tests them monthly, he did not have records of performing them. Record review that same day confirmed that finding.</p> <p>3. Observation and testing on 11/13/25 on at 12:11 p.m. revealed the battery pack emergency light marked number four did not operate on the battery backup when that circuit was tested. Interview with maintenance director H at the same time as the observation confirmed that condition. When asked if he had documentation of the testing required for emergency lights, he stated he usually tests the emergency lights randomly and while he tests them monthly, he did not have records of performing them. Record review that same day confirmed that finding.</p>	S 201		

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S 215	<p>44:70:03:03 Fire Extinguisher Equipment</p> <p>Fire extinguisher equipment shall be installed and maintained to the following standards:</p> <p>(1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C;</p> <p>(2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and</p> <p>(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.</p> <p>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 fire extinguishers in accordance with NFPA 10 on four randomly checked fire extinguishers (A2, A1, maintenance shop elevator, and equipment room) since the annual inspection. Findings include:</p> <p>1. Observation and interview on 11/13/25 at 11:12 a.m. revealed the fire extinguisher marked A2 did not have monthly maintenance checks written on the fire extinguisher tag for the month of October 2025. Interview with maintenance director H at the time of the observation revealed he was unaware of that condition. He stated the maintenance</p>	S 215	<p>Fire extinguishers were immediately checked by MD. Fire extinguisher checks will be documented in Tels monthly by MD.</p> <p>Ed or designee will review monthly until compliance is achieved.</p>	11/9/25

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S 215	<p>Continued From page 5</p> <p>technician performed all the maintenance on those devices.</p> <p>2. Observation and interview on 11/13/25 at 11:37 a.m. revealed the fire extinguisher marked A1 did not have monthly maintenance checks written on the fire extinguisher tag for the month of October 2025.</p> <p>Interview with maintenance director H at the time of the observation revealed he was unaware of that condition. He stated the maintenance technician performed all the maintenance on those devices.</p> <p>3. Observation and interview on 11/13/25 at 1:27 p.m. revealed the fire extinguisher in the maintenance shop/office/boiler room did not have any monthly maintenance checks written on the fire extinguisher tag 2025.</p> <p>Interview with maintenance director H at the time of the observation revealed he was unaware of that condition. He stated the maintenance technician performed all the maintenance on those devices.</p> <p>4. Observation on 11/13/25 at 1:42 a.m. revealed the fire extinguisher in the elevator equipment room did not have any monthly maintenance checks written on the fire extinguisher tag for 2025.</p> <p>Interview with maintenance director H at the time of the observation revealed he was unaware of that condition. He stated the maintenance technician performed all the maintenance on those devices.</p>	S 215		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty	S 296		

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S 296	<p>Continued From page 6</p> <p>days of hire for all healthcare personnel and must include the following subjects:</p> <p>(1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility.</p> <p>Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8).</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview the provider failed to ensure the required training was completed within 30 days of hire for three of five</p>	S 296		

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S 296	<p>Continued From page 7</p> <p>recently hired employee (C, D and E).</p> <p>1. Review of the personnel file for the medication assistant (MA) C revealed: *She was hired on 9/15/25. *She had not completed training on fire prevention and safety and response, emergency preparedness and infection control. *Her training for accident prevention and safety was completed on 11/6/25.</p> <p>2. Review of the personnel file for MA D revealed: *She was hired on 6/23/25. *Her training for accident prevention and safety and diseases reporting training was completed on 8/1/25, and the nutritional risk and hydration training on 8/2/25. -The training had been completed more than 30 days after she was hired.</p> <p>3. Review of the personnel file for MA E revealed: *She was hired on 5/27/25. *She had not completed her emergency procedure and preparedness training. *The fire prevention and response training was completed on 9/17/25 and nutritional risks and hydration training on 9/19/25. -The training had been completed more than 30 days after she was hired.</p> <p>4. Interview on 11/13/25 at 2:30 p.m. with executive director A revealed: *She expected training to be completed within 30 days of hire and was not sure why it had not been completed. *The staffing training policy was requested however, she did not have that policy.</p>	S 296	<p>All Employee files will be audited by BOM before 12/10/25. All Files will be brought into compliance.</p> <p>Audits will monitored on a monthly basis until compliance achieved.</p> <p>This will be monitored by ED or designee</p>	12/10/25

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S 305	Continued From page 8	S 305		
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, and interview the provider failed to ensure the health status for communicable diseases were evaluated by a licensed health professional within 14 days of hire for three of ten sampled employees (D, F and G). Findings include: 1. Review of medication assistant (MA) D's personnel file revealed: *Her date of hire was 6/23/25. *She completed her health evaluation form on 6/20/25 was not signed by a licensed health professional. 2. Review of MA F's personnel file revealed: *Her date of hire was 1/3/25. *Her health evaluation form was not signed by a licensed health professional. 3. Review of culinary service director G's personnel file revealed: *Her date of hire was 11/21/24. *Her health evaluation form was not signed by a licensed health professional. 4. Interview on 11/13/25 at 11:30 a.m. with health	S 305	All Employee files will reviewed by BOM by 12/10/25 Audits will be monitored on a monthly basis during monthly safety meeting until compliance is achieved. This will be monitored by ED or designee	12/10/25

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S 305	Continued From page 9 service director (HSD) B revealed she had not completed those health evaluations, but they should have been completed. She did not have a policy regarding the health evaluations.	S 305		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. 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 an evaluation of the resident needs was completed at 30 days for one of eight sampled resident (1). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He admitted to the facility on 5/31/23. *His evaluation of resident need for his admission was completed on 5/31/23. *His 30-day evaluation of resident need was completed on 12/27/23. That was not within the required timeframe of 30 days after admission. 2. Interview on 11/13/25 at 8:50 a.m. with health service director (HSD) B revealed: *She was hired on 12/11/23. *Nurses were responsible for completing the evaluation of resident need on admit, 30-days after admission, with a change of condition, and	S 352	<p>ED reeducated HSD and RCC on requirements for 30 day assessment on 11/15/25</p> <p>We will monitor 30 day assessments for all move in's Weekly X 4 weeks and then Monthly until compliance is achieved.</p> <p>HSD or designee will complete 30 day assessments for all residents.</p> <p>ED will monitor HSD compliance monthly until compliance is</p>	

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S 352	<p>Continued From page 10</p> <p>annually.</p> <p>*She agreed the evaluation of resident need had not been completed 30-days after his admission.</p> <p>3. Review of the provider's revised 3/10/23 Resident Evaluation and Service Plan policy revealed:</p> <p>*"A complete needs evaluation will be conducted to determine the level of assistance required to maximize each Resident's quality of life and to maintain compliance with state regulations. Thorough and timely evaluations will ensure that Resident care needs are identified and that an individualized service plan is maintained which addresses those specific needs. The evaluation also assists in determining the prospective Resident's suitability for placement in the assisted living or memory care setting."</p>	S 352		
S 485	<p>44:70:06:11(1-3) ServSafe And Nutritional Needs</p> <p>The dietary manager, if employed, and at least one cook shall:</p> <p>(1) Successfully complete a ServSafe Food Protection Program and possess a current certificate;</p> <p>(2) Successfully complete the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association; or</p> <p>(3) Successfully complete equivalent training as determined by the department.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on interview the provider failed to ensure</p>	S 485	<p>Serve safe food program scheduled for cook on 12/12/25.</p>	12/12/25

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S 485	<p>Continued From page 11</p> <p>at least one employed cook had completed and possessed a current ServSafe Food Protection Program certificate.</p> <p>Findings include:</p> <p>1. Interview on 11/12/25 at 9:30 a.m. with administrator A revealed:</p> <ul style="list-style-type: none"> *She stated director of culinary services (DCS)(G) was ServSafe certified however, she was not aware two employees certified in ServSafe Food Protection was required. -She stated she did not have a policy for dietary training. 	S 485		