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
	67721	A. BUILDING: _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT SKYLINE PINES	1050 FAIRMONT BLVD RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 1/17/24 through 1/19/24. The Village at Skyline Pines was found not in compliance with the following requirements: S105, S130, S165, S201, S295, S325, S337, S375, S405, S415, S450, S685, and S835. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 1/17/24 through 1/19/24. Areas surveyed included quality of life, resident neglect, and physical environment. The Village at Skyline Pines was found not in compliance with the following requirements: S415 and S835.	S 000		
S 105	44:70:02:06 Food Service Food service must be provided by a facility licensed in accordance with SDCL chapter 34-12 or food service establishment licensed in accordance with SDCL chapter 34-18 that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain and clean the following kitchen equipment and surfaces: *Two of two microwaves.	S 105	Assistant Administrator will update daily, weekly, and monthly cleaning schedules to verify they cover the noted items, and verify that all noted items were cleaned. Assistant Administrator, Registered Dietician, and Dietary Manager will continue identifying areas of concern for cleaning in an ongoing fashion and will update the cleaning schedule as necessary. All Dietary staff will be educated by Assistant Administrator on proper cleaning requirements for kitchen and equipment and the expectation that tne cleaning policy be followed either during all staff meeting or through direct one on one or small group training. Maintenance will be instructed to change all filters in kitchen equipment in accordance with manufacturer recommended schedules.	3/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli J. Back — TITLE: Administrator — (X6) DATE: 2/26/24

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S 105	Continued From page 1 *One of one front-feeding toaster. *One of one convection oven. *One of one specialty oven. *One of one steam table. *One of one deep fat fryer. *One of one kitchen floor. *One of one ice machine. Findings include: 1. Observation and interview on 1/17/24 at 9:05 a.m. with assistant administrator F in the kitchen revealed: *There were two microwaves in the kitchen. -Both of the microwaves had hard-crusted chunks of food in the inside with grease buildup on the outside of the microwaves. *The front-feeding toaster was placed on a baking sheet across from the steam table. -The baking sheet had a thick buildup of crumbs under the toaster and around the legs of the toaster. *The convection oven had black burnt food particles on the bottom surface and dark brown streaks on the glass. *The specialty oven had thick white buildup on the bottom of the stove and around the front of the stove where the door sealed, and directly under the oven. -There were four shelves under the specialty oven that had stored the oven racks. --The shelves had thick white buildup on them and brown splatter marks down the front of them. *The steam table had three compartments. -The three compartments had cloudy water with chunks of debris floating in each of them. -The three compartments of the steam table had hard-crusted buildup of what appeared to be mineral buildup. *The deep fat fryer had hard burnt food particles floating on the top of the grease and there was	S 105	(Cont from pg1) Assistant Administrator will audit 2x per week for 90 days, then quarterly for 9 months to verify compliance and report to the QAPI team at least quarterly. These audits will be verifying that all cleaning duties are being completed as scheduled and all noted items are sanitary, and proper documentation of the cleaning is being done. Update of policy is not required. Had policy been followed unclean conditions would not have occurred. All items noted as deficient have been cleaned.	

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S 105	Continued From page 2 grease buildup around the outside of the fryer. *The floor under the dishwasher had three black milk crates that were sitting upside down. -There was thick dark buildup around the bottoms of the black milk crates. *The ice machine had a thick buildup of dust on the outside of the filter. -The filter was bent and did not appear to be in place. *Assistant administrator F was responsible for oversight of the kitchen. -She agreed that the above kitchen areas were unclean and not sanitary. -She did not have any past or current kitchen cleaning logs that have been completed. -She agreed that daily, weekly, and monthly cleaning logs should have been completed according to policy. Interview on 1/17/24 at 9:20 a.m. with dietary staff H revealed: *The kitchen does not have a cleaning log that kitchen staff follow. *All of the kitchen staff are reponsible for cleaning the kitchen. *He is the only kitchen staff that did any cleaning in the kitchen. Interview on 1/19/24 at 12:06 p.m. with administrator A and general manager B revealed: *Assistant administrator F was responsible for the oversight of the kitchen, and she had informed them of the above identified issues in the kitchen. *The ice machine was not being used and should have been removed from the kitchen. *They agreed there should have had daily, weekly, and monthly cleaning logs completed and kept for the kitchen. *There were no current or past cleaning logs for the kitchen or the kitchen equipment.	S 105		

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S 105	Continued From page 3 *Kitchen manager G was responsible for ensuring the kitchen was clean and sanitary. Review of the provider's 7/5/21 "Ice Maker sanitation" policy revealed "On a monthly basis our ice machine will be shut down, inspected, and cleaned as necessary." Review of the provider's 4/16/21 "Dietary Cleaning" policy revealed "Dietary employees follow and initial on a Daily, Weekly and Monthly Cleaning Checklist and maintain all kitchen equipment in a sanitary manner."	S 105		
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following: *Proper glove use by one of one unlicensed medication aide (UMA) (K) during medication administration for one of one sampled resident (12) in the memory care unit (MCU). *Cleaning and disinfection of the vitals signs	S 130	All staff, including those identified during the survey, will receive training on proper use of gloves,hand sanitizer, and hand washing requirements in order to maximize infection control efforts. This training took place during the all staff meeting, and/or by handout for staff not present during the meeting. One on one or small group training from Nurses or Shift leads also conducted for those not present. Education will also be provided on current infection control policies. Care staff will receive training on how to sanitize multi use medical equipment between residents and after use during staff meeting, or by handout followed by one on one or small group training from Nurses or Shift leads. Care staff will be instructed on the importance of using barriers when placing instruments or other care items on counters, tables, and floors during staff meeting, or by handout followed by one on one or small group training from Nurses or Shift leads. Sanitary wipe holders will be installed on vitals towers and mechanical lifts, and at several locations through the facility to provide better access for staff.	3/4/24

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S 130	Continued From page 4 equipment: -In the MCU by one of one resident care assistant (RCA) (M) after it was used for one of one sampled resident (10). -In the main dining room by one of one UMA (P) after it was used for one of one unidentified resident. *Proper glove use by two of two RCAs (I) and (J) during personal care for one of one sampled resident (29). *Barrier placement and cleaning of reusable medication supplies in one of one sampled resident's (20) room by one of one registered nurse (RN) (E). *Proper hand hygiene and cleaning/disinfecting of mechanical stand aide lift by one of one RCA (T) and one of one certified nursing assistant (CNA) (L) in the MCU. *Proper glove use by one of one RCA (T) during personal care for one of one sampled resident (28) in the MCU. Findings include: 1. Observation and interview on 1/17/24 at 4:40 p.m. with UMA K during medication administration in the MCU revealed she: *Removed a clean pair of gloves from the dispenser on top of the medication cart and placed them inside her smock pocket. -Entered the locked medication room, opened a locked medication box from inside the medication refrigerator, and set the box on the counter. -Removed the gloves from her smock pocket and without performing hand hygiene put them on. -"Dialed" the prescribed amount of prescription cream from its dispenser and dispensed the cream into a medication cup. -Used her gloved hands to lock the medication box and return it to the refrigerator before opening the medication room door and exiting.	S 130	(Cont from pg 4) Each audit will be conducted by shift leads on their respective shifts, monitoring randomly at least 5 instances per week per shift for improper hand hygiene, glove use, and barrier use. Shift leads will verify that the wheelchair cleaning schedule is being followed by inspecting at least 3 random wheelchairs per week per week per shift and will report to Nurses if quality is not acceptable. Nurses will inform QAPI group of the outcomes of the audits and suggest further improvements as necessary. QAPI group will monitor compliance with IC policies and verify documentation on audits are being done correctly at least weekly for the first 3 months, then quarterly thereafter for the next 9 months. Infection control polices were reviewed for any updates by QAPI team.	

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S 130	Continued From page 5 -Proceeded to resident 12's room and with her unclean gloved right hand used her index finger to scrape the cream out of the medication cup and applied it to the inside of the resident's wrist. *Agreed her gloves were unclean after she removed them from inside of her smock pocket. -The gloves were further contaminated after she touched the medication refrigerator, the locked medication box, the key for the medication box, and the medication room door. 2. Observation and interview on 1/17/24 at 5:00 p.m. with RCA M in the MCU after he had taken resident 10's vital signs revealed he: *Returned the blood pressure cuff and pulse oximeter he had used with the resident inside the wire basket on the vitals cart. -There were no disinfectant wipes inside the wire basket to clean the cuff or oximeter. *Returned the vitals cart to an area behind the nurses' station next to a copy machine. *Knew the vitals equipment was expected to have been cleaned after it was used. -The vitals signs machine was used for multiple residents. -Disinfectant wipes were not available otherwise he would have cleaned the cuff and oximeter. Interview on 1/19/24 at 10:45 a.m. with administrator A and general manager B regarding the above observations revealed: *Gloves kept inside personal clothing pockets then used during resident care tasks posed an infection control risk. *Gloves not changed between touching uncleaned and cleaned surfaces posed an infection control risk. -UMA K's gloves were unclean during the process of preparing and administering resident 12's prescription cream.	S 130		

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S 130	Continued From page 6 *Reusable medical equipment was to have been disinfected after each resident's use. -Disinfectant wipe dispensers were expected to have been stored inside the wire basket of the vitals cart to ensure accessibility to the staff for disinfection of the reusable equipment. 3. Observation and interview on 1/18/24 at 11:57 a.m. with RCA I and J during resident 29 personal care revealed: *They assisted resident 29 to the bathroom. *Without performing hand hygiene and putting on a pair of gloves, RCA J pulled resident 29's pants down, tore the edges of her incontinence undergarment and removed the soiled incontinence undergarment. *Without washing her hands and putting gloves on, RCA J put resident 29's clean incontinence undergarment on. -RCA J placed the incontinence undergarment foot holes through resident 29's pants and around her shoes and then placed the incontinence undergarment under her pants. *With her gloves on RCA I performed personal hygiene care on resident 29, and without changing her gloves or washing her hands she pulled up resident 29's incontinence undergarment and then her pants. *RCA J agreed she should have performed hand hygiene and worn gloves when she removed resident 29's soiled incontinence undergarment. *RCA J agreed she should have not pulled resident 29's clean incontinence undergarment around her shoes since that could contaminated it. *RCA I agreed she should have removed her soiled gloves after performing the resident's personal care. -She should have washed her hands, and then put on a clean pair of gloves to pull up resident	S 130		

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S 130	Continued From page 7 29's clean incontinence undergarment and pants. Interview on 1/19/24 at 10:44 a.m. with administrator A and general manager B revealed they agreed that: *RCA J should have worn a pair of gloves while removing resident 29's soiled incontinence undergarment. *RCA J should have washed her hands and put on a clean pair of gloves to place the clean incontinence undergarment on resident 29. -Putting the clean brief on through resident 29's pants and around her shoes was not acceptable practice. *RCA I should have taken off her soiled gloves after performing personal hygiene care, washed her hands, and then should have put on a clean pair of gloves to pull up resident 29's clean incontinence undergarment and pants. 4. Observation on 1/17/24 at 4:30 p.m. of the second-floor main dining room revealed: *UMA P removed a vitals machine cart from a storage area and obtained a blood pressure reading from an unidentified resident sitting in the dining room. -She had not cleaned and disinfected the blood pressure cuff after removing it from the resident's arm and winding the cuff and attached cord around the top of the vitals cart. -She returned the cart back to the storage area then continued to perform other duties. *Disinfectant wipes were not available on the above cart to clean and disinfect the blood pressure cuff. 5. Observation and interview on 1/18/24 at 11:25 a.m. in resident 20's room with RN E during insulin administration revealed: *Resident 20 was on contact precautions related	S 130		

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to a urinary tract infection.
-She was an insulin dependent diabetic.
*Before entrance into the room, RN E removed the resident's insulin pen and laminated sliding scale instructions from the medication cart drawer and brought them into resident 20's room.
-She placed the insulin pen and instructions sheet directly onto resident 20's over bed table without placing a barrier under the items.
-She sanitized her hands and applied a clean pair of gloves.
*Following administration of the insulin, RN E had:
-Set the items back on the resident's over bed table.
-Removed her gloves, and performed hand sanitization.
*She applied a new pair of gloves then:
-Took the insulin pen and instructions sheet from the room and returned to the medication cart without sanitizing those items.
-Placed those contaminated items on the top of the medication cart.
-Removed an alcohol swab from the cart and cleansed the upper half of the insulin pen and replaced the insulin cap.
*She had not sanitized the lower portion of the pen, the cap, the laminated instructions sheet, or the medication cart surface.
-She then removed her gloves, performed hand sanitization, and returned those contaminated items into the medication cart drawer.

Interview on 1/18/24 at 11:45 a.m. with RN E regarding the above observations revealed she:
*Had been hired in April 2023.
*Had not received any ongoing infection control (IC) training or testing other than during her initial training.
*Stated, "It's not a common practice for the

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S 130	Continued From page 9 nurses to administer insulin here, usually the UMA's do it." *Was unable to identify any missing IC practices that had occurred during the above observations. *Agreed she had missed: -Placing a barrier under the medication supplies while in resident 20's room. -Proper disinfection of those supplies before returning them to the medication cart drawer. Interview on 1/19/24 at 10:44 a.m. with administrator A and general manager B regarding the above observations revealed: *General manager B stated he had not seen any "big issues" with staff's IC practices prior to those observations. *Administrator A stated they had been focused on Covid-19 infection control practices for the past three years and there was no focus on other IC practices. 6. Observation on 1/18/24 from 1:18 p.m. through 1:37 p.m. with RCA T and CNA L revealed they: *Had three unidentified residents that needed transferred from each of their wheelchairs (w/c) to a recliner using a mechanical stand aide lift. *Assisted the residents by placing their feet on the footplate and their hands on the upper grab bars to hold onto during the transfers. *Placed the safety belt around the resident's upper body and hooked it to the stand lift and lifted the resident out of their w/c and wheeled them over to the recliner. *Unhooked the resident from the stand aide lift, offered to lift the recliner legs up and then offered the resident a blanket and then left the room. *Had not cleaned or disinfected the stand aide lift between the use of any of the residents' transfers, and CNA L performed hand hygiene one time between all three residents.	S 130		

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S 130	Continued From page 10 7. Observation on 1/18/24 at 4:14 p.m. with RCA T and CNA L revealed: *There was a resident who needed to be toileted in the central bathing room by using a mechanical stand aide lift. *They assisted the resident by placing her feet on the footplate and her hands on the upper grab bar to hold onto during the transfer. *RCA T put on a pair of gloves and took off the resident's pants and her brief and CNA L lowered the resident onto the toilet. *RCA T removed her gloves and left the room to get another pair of pants and a clean brief without performing hand hygiene. *CNA L put on a pair of gloves and placed the resident's pants in a trash bag and then removed her gloves and washed her hands. *RCA T came back and put a pair of gloves on and moved the wheelchair closer to the resident, got the wet wipes out while CNA L put the pair of clean pants on the resident and pulled them up to her knees. *CNA L lifted the resident in the stand lift, RCA T used the wet wipes to perform the residents personal care and with those same gloves put a clean brief on the resident and pulled the resident's pants, RCA T assisted CNA L in moving the stand aide lift over to the resident's w/c, guided the resident down into her w/c and unhooked the resident from the stand lift. *With those same contaminated gloved hands RCA T pulled the resident's shirt down and opened the door for CNA L and the resident to leave, she then took the gloves off and washed her hands. Interview on 1/18/24 at 4:35 p.m. with RCA T and CNA L about the above observations revealed: *They were to clean and disinfect the stand aide	S 130		

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S 130	Continued From page 11 lift once a day or if they saw something noticeable on it, something that needed to be cleaned. -CNA L thought it could also be done once a shift. *RCA T agreed that she should have taken her gloves off after performing personal care and sanitized her hands before putting on a the resident's clean brief. *Hand hygiene was to have been performed between each resident care task. Review of the undated Infection Control policy revealed: *"Preventing spread of infectious organisms through use of proper hand cleansing and gloving procedures is required to reduce and eliminate modes of transmission to prevent and contain infection among residents, staff, and community at large." *"Hand soap, disposable towels, hand gel, or gloves will be available for employee use in residents' rooms to minimize the sources and transmission of infectious diseases to residents, personnel, visitors, and the community at large." Review of the provider's 7/25/21 Sanitization/Cleaning of Medical Equipment policy revealed "Medical equipment must be sanitized between uses of different residents and as often as reasonably possible even when used by the same resident in order to keep a sanitary condition and limit spread of infectious agents."	S 130		
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the	S 165	The roof access door on 3B has been secured. The laundry chute on 3A has been secured. By 3/4/24 Maintenance will complete weekly inspections of all exterior doors to verify locks work as they should. Documentation of these checks will be verified by the QAPI team monthly for the first	3/4/24

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(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 165	Continued From page 12 physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure resident safety and security was maintained by preventing: *Door access to the rooftop through one of one resident-use laundry room located on the third floor (wing 3B). *Access to a laundry chute for soiled laundry in one of one resident-use laundry room located on the third floor (wing 3A). *Construction debris from laying on the floor and creating a fall hazard in one of one resident-use laundry room that was located on the third floor (wing 3A). *Unrestricted access for cognitively impaired residents to two of two hot beverage dispensers in the memory care unit (MCU) that posed a burn hazard. Findings include: 1. Observation on 1/17/24 at 9:15 a.m. of the resident-use laundry room located on the third floor wing 3B revealed: *Inside the resident-use laundry room, and located on the opposite wall from the laundry room entrance, there was an unlocked and unalarmed door that allowed access to a separate room and a stairway to the rooftop door. -There was a square hole next to the inside of the access door that contained loose wires. -That room contained multiple large cardboard boxes, multiple unused furnace filters that were laying on the floor and on top of the boxes, and construction materials leaned up against the far	S 165	(Cont from page 12) 3 months, and if no occurrences are missed, quarterly thereafter. All construction materials have been removed from all resident accessible areas. Maintenance has been instructed that it is not appropriate to store construction materials in resident accessible areas. Managment team spoke at the all staff meeting about the need to be vigilant in regards to any unsafe conditions. They were instructed to relay any potential unsafe conditions to maintenance or management. The Maintenance Supervisor job description was reviewed and updated to include the door system checks, and inspections for unsafe conditions. The GM reviewed UBC, NFPA 101, and 44:70 regs. Hot beverage machines will be removed from MC resident accessible areas. Care staff were instructed to provide hot beverages upon request to MC residents. During monthly all staff meetings, a discussion will be held regarding any unsafe resident conditions. Staff will be educated to report these immediately to management. Management will evaluate all concerns and take appropriate action. These will be reviewed by the QAPI team monthly for 12 months.	

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S 165	Continued From page 13 wall that included plywood and broken Styrofoam pieces. -On the right side of the room there was a four step stairway that held construction debris containing a box of miscellaneous nails and screws, two small wood blocks, and a metal pole leaned against the top of the stairway next to the door. -At the top of the stairway there was an unalarmed door that the surveyor opened. -It led straight to the snow-covered outside rooftop. Continued observation of the above resident-use laundry room on 1/17/24 at 3:57 p.m. and again on 1/18/24 at 9:11 a.m. revealed the same findings. Observation and interview on 1/18/24 at 9:45 a.m. with general manager (GM) B in wing 3Bs resident-use laundry room revealed: *He was responsible for overseeing the maintenance department. *He and maintenance supervisor C were responsible for ensuring all outside doors were either locked or alarmed. -There was no documentation of the monitoring of the outside doors. -He depended on staff to let him know if a door was not working properly. *He stated the alarm to the inside door allowing access to the room and rooftop door had not been functioning, but the inside access door was locked. -"(Name of alarm company) were here last Friday and removed the access door's alarm to repair it, they did not have the right supplies, and have not returned since." *He was not aware the inside access door was not latching shut causing it to remain unlocked.	S 165		

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S 165	Continued From page 14 -Upon GM B's inspection of the inside access door, he revealed the door's self-latch lock did not shut properly due to a bent metal piece on the door frame. *He confirmed this was a safety risk to all residents who had access. *His expectation was for the door to remain locked at all times. Interview on 1/18/24 at 10:00 a.m. with maintenance supervisor C revealed he: *Had last checked wing 3Bs inside access door when assisting the alarm company six days ago. -Thought the door was locked at that time. -Normally checked all exit doors once a week, but had not documented any monitoring of those doors. *Was not aware the access door was not closing properly and locking. -Confirmed the unlocked door was a safety risk to all residents who had access. 2. Observation on 1/17/24 at 8:57 a.m. of the resident-use laundry room located on the third floor wing 3A revealed: *On the inside right wall of the resident-use laundry room there was a square metal door measuring about two-and-a-half feet wide located about two feet above the floor. -The door's handle was unlocked and when the surveyor opened the latch, it revealed a round laundry chute measuring about two-and-a-half feet in circumference that extended down to the second-floor main laundry room. -The opening was large enough for a small or thin person to bend over and fall through it. Observation and interview on 1/18/24 at 9:45 a.m. with GM B in 3As resident-use laundry room revealed:	S 165		

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S 165	Continued From page 15 *He agreed the laundry chute door was not locked. *Stated the staff's general access key would lock the laundry chute door. -Upon several attempts, the key could not lock the laundry chute's door. *He would check with maintenance staff to locate the key so staff could lock the laundry chute. Further interview on 1/19/24 at 10:45 a.m. with GM B and administrator A revealed they agreed the unlocked access door and laundry chute door were a problem and stated further staff education was needed regarding resident safety. 3. Observation on 1/17/24 at 9:00 a.m. of the resident-use laundry room located on the third floor wing 3A revealed: *A wall along the left-hand side of the resident-use area contained multiple types of construction debris laying on the floor extending out approximately three feet onto the floor and down the entire length of the wall. -That debris consisted of sheet rock, plumbing supplies, lumber, and long thin strips of metal with sharp edges. Further observation and interview on 1/18/24 at 9:45 a.m. with GM B in 3A's resident-use laundry revealed: *He stated there was no substantial construction currently occurring on the third floor. -He agreed those items should not have been in a resident-use area and could have posed a fall risk to the residents. -He stated they had multiple storage rooms and was unsure as to why those items were left on the floor. 4. A resident safety policy was requested on	S 165		

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S 165	Continued From page 16 1/18/24 at 3:45 p.m. from GM B and was not received by the end of survey on 1/19/24. Review of the provider's undated 'Maintenance Supervisor' policy revealed: *"Job summary. Responsible for the proper operation and interior and exterior maintenance of all aspects of the physical plant, equipment, mechanical systems and grounds." *"Performance Requirements." -"2. Responsible for safe and efficient operation of the physical plant and equipment related to the property." -"5. Establish, follow, and document complete, routine and Preventative Maintenance Plan for plant, equipment, fixtures and furnishings." 5. Observation on 1/17/24 at 3:50 p.m. in the MCU assisted dining area revealed: *There was a juice dispenser, coffee dispenser, and hot water dispenser on the west countertop. -Without supervision resident 1 dispensed juice into a lavender disposable cup. *There were no mechanisms on the two hot beverage dispensers that prevented resident 1 from dispensing either the hot water or coffee into his lavender cup. -The temperature of sampled hot water was 169 degrees Fahrenheit (F) and the temperature of sampled coffee was 168 degrees F. Review of resident 1's electronic medical record revealed his 12/8/23 Brief Interview for Mental Status score was "5" indicating he had severe cognitive impairment. Interview on 1/18/24 at 8:20 a.m. with certified nurse aide L regarding the hot beverage dispensers in the MCU revealed:	S 165		

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S 165	Continued From page 17 *All MCU residents had unsupervised access to all the beverage dispensers referred to above. -"They [residents] just have to ask staff for a cup." *She agreed not all MCU residents had the verbal skills or cognitive ability to have asked for a cup. -Those residents had the potential to have dispensed a hot beverage without staff supervision and potentially burn themselves. Interview on 1/19/24 at 11:15 a.m. with administrator A and general manager B regarding the hot beverage dispensers in the MCU revealed: *There were no safety features on either of those hot beverage dispensers that would have mitigated a resident's burn risk. -No options were explored to keep the MCU residents who were at higher risk for accidents safe around those hot beverage dispensers. *There were no known residents who were burned using those dispensers but the potential for a burn injury existed. *Residents' families wanted access to those dispensers when they visited. A Resident Safety policy related to hot beverages was requested on 1/18/24 at 3:45 p.m. General manager B stated the provider had no policy related to that.	S 165		
S 201	44:70:03:02 General Fire Safety 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	S 201	A. A battery continuity tester has been purchased and the generator battery continuity will be tested monthly going forward, and the results will be logged. This testing will initially be audited by our QAPI group once per month for the first 90 days, and if no occurrences are missed, we will audit quarterly after the initial period for 12 months B. A satellite generator annunciator will be installed.	3/4/24

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S 201	Continued From page 18 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 record review and interview, the provider failed to document generator battery conductivity monthly (no documentation for 2023). Findings include: 1. Record review on 1/17/24 at 8:30 a.m. revealed there was no documentation of the battery conductivity in the monthly maintenance logs for the generator for the calendar year 2023. Interview on 1/17/24 at 8:45 a.m. with the maintenance supervisor C revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. He stated he was unaware of the monthly battery conductivity documentation requirement. B. Based on observation and interview, the provider failed to have a generator annunciator in a 24-hour manned location (electrical room on the main floor). Findings include: 1. Observation on 1/17/24 at 9:45 a.m. revealed the annunciator for the 450-kW diesel generator was located within the electrical room on the main floor, across the hall from the maintenance shop. The electrical room and the maintenance shop were not 24-hour manned locations. A generator required a monitored alarm/annunciator. There was no annunciator at a continuously occupied space (nurse's station, for example) that would indicate when the generator was in a trouble status.	S 201	(cont from pg 18) The new annunciator will be placed in close proximity to the MC Nurses station. C. The kitchen pantry door has been made self closing. D. Staff (and affected outside vendors) will be educated on the importance of keeping doors closed for separation for smoke and fire containment, and that door stops and other methods of holding doors open that do not automatically close, are not allowed. The striker has been replaced in the kitchen door. E. The schedule of the sprinkler flow tests for 2024 will be verified, and every effort will be made to ensure the vendor can complete the tests on the quarterly schedule going forward. A secondary vendor will be noted and should the primary vendor not meet the schedule withing 15 days of expiration the secondary vendor will be called to perform the testing. Maintenance will be responsible for monitoring the schedule, and this will be audited by the QAPI group quarterly for 6 months and annually after that if no missed occurrences are found. F. The arm to the door closer on 3A laundry room has been reinstalled. Maintenance will be instructed not to disable door closers.	

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S 201	Continued From page 19 Interview with the administrator on 1/17/24 at 11:45 a.m. confirmed that finding. C. Based on observation and interview, the provider failed to maintain proper separation of one of four hazardous areas (the kitchen pantry) in one randomly observed area (the kitchen). Findings include: 1. Observation on 1/17/24 at 10:30 a.m. revealed the kitchen pantry storage room was over 100 square feet in area containing copious amounts of combustible items (various cardboard boxes and cooking oils). The door to the storage room within the kitchen was not equipped with a self-closing device. Interview with maintenance supervisor C at the time of the observation confirmed that finding. Doors to hazardous areas were required to be self-closing. D. Based on observation and interview, the provider failed to maintain proper smoke-tight separation of two randomly observed areas from the common area (the kitchen and the hairstyling salon). Findings include: 1. Observation on 1/17/24 at 9:45 a.m. revealed the door adjacent to the Type K fire extinguisher in the kitchen was equipped with a closer but would not latch into the frame. Further observation revealed the striker had been removed from the door, rendering it incapable of latching as required. The door led from the kitchen to the second-floor dining area which was open to the main entrance and lobby on the first floor.	S 201		

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S 201	Continued From page 20 2. Observation on 1/17/24 at 9:45 a.m. revealed the door for the hairstyling salon was held open with a rubber floor wedge. Wedges were not approved hold-open devices for doors. 3. Interview with the maintenance supervisor C at the times of the observations confirmed those findings. E. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test was not completed in two quarters of 2023). Findings include: 1. Record review on 1/17/24 at 8:30 a.m. revealed the total required quarterly flow tests had not been performed in the past year. Flow tests in the past twelve months were performed in June 2023 and December 2022. Documentation revealed quarterly flow tests had not been performed and were not available for March 2023 or September 2023. 2. Interview with maintenance supervisor C at the time of the record review confirmed that condition. He stated the provider had switched sprinkler contractors in 2023. Failure to continuously maintain the automatic sprinkler system as required increased the risk of death or injury due to fire. F. Based on observation, interview, and policy review, the provider failed to maintain a proper smoke-tight separation of a resident-use laundry room from a common hallway in one of one resident-use laundry rooms located on the third floor wing (3A). Findings include: 1. Observation and interview on 1/18/24 at 9:45	S 201		

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S 201	Continued From page 21 a.m. with general manager B of wing 3A's resident-use laundry room revealed the self-closing device to the laundry room door had been removed, causing the door to not latch shut. General manager B stated it had been removed to accommodate a resident complaint of the door being too difficult for her to push open. 2. Interview on 1/18/24 at 10:00 a.m. with maintenance supervisor C confirmed that finding. Doors to hazardous areas were required to have been self-closing. 3. Review of the provider's undated Maintenance Supervisor policy revealed: "Performance Requirements. 4. Ensure all company, state, local or federal health, safety, health [sic], building, fire and insurance codes or requirements are met or exceeded at all times."	S 201		
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, record review, interview, and policy review, the provider failed to ensure the following: *A formal orientation training program was completed within 30 days of hire by one of four recently hired sampled employees (T). *An annual training program was completed by one of two sampled employees (P).	S 295	Any staff who have not completed their onboarding or annual required trainings will not be put on the schedule for work until courses are complete. This will be monitored by Assistant Administrator through use on online tools at least monthly. This will be verified by our QAPI team monthly for 6 months. Fire drill schedule will be updated to include at least 2 full building evacuations during sleeping hours. All staff will be instructed to remove all residents from the effected area, to an area beyond a fire door or out of the building, whichever is faster regardless of weather condition or resident resistance. In the case of a full building evacuation drill, all residents must be moved outside regardless of weather. This policy is being evaluated for improvements by Craig Holden, and the RC fire department.	3/4/24

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S 295	Continued From page 22 *A complete documented fire emergency training for employees. Findings include: 1. Review of employee T's personnel file revealed: *She was re-hired on 10/5/23. *Two required orientation training topics were documented as completed within 30 days of her re-hire date: abuse, neglect, misappropriation of resident property and funds and resident rights. *The remaining nine required orientation training topics were documented as completed between 3/31/22 and 4/1/22: --Fire prevention and response. --Emergency procedures and preparedness. --Infection control and prevention. --Accident prevention and safety procedures. --Resident rights. --Confidentiality. --Incidents and diseases subject to mandatory reporting. --Nutritional risks and hydration. --Problem solving and communication techniques related to the resident with cognitive impairment or challenging behaviors. 2. Review of employee P's personnel file revealed: *She was hired on 12/1/20. *She had no documented required annual training completed in 2023. -Her required annual training was last documented as completed between 4/24/21 and 11/30/22. Interview on 1/18/24 at 4:30 p.m. with assistant administrator F revealed she: *Was responsible for ensuring required orientation training for new employees was	S 295	Continued from page 22 QAPI group will monitor compliance monthly for 12 months to verify all staff trainings were complete, or that all staff who did not complete their training were removed from the schedule. We are also verifying that fire drills are needing the more rigorous standard.	

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completed within 30 days of their hire date and required training was completed annually for all other employees.
*Reminded staff about those training requirements at the All Staff meetings, through e-mail communications, and other postings.
*Knew some staff were not compliant with meeting training requirements on time.
*Confirmed employee T had not completed her required orientation training within 30 days of her hire date and employee P had not completed her required annual training within the last year.

Review of the provider's 5/25/21 Personnel/Staff Training policy revealed:
*"This facility has a formal orientation program and ongoing education program for all personnel."
-That program included eleven required training topics referred to above.
3. Record review on 1/17/24 at 9:15 a.m. revealed the provider performed one fire drill per month for the building.

Interview with administrator A on 1/17/24 at 10:00 a.m. revealed fire drills were conducted in one specific wing at a time. The building was divided into five separate wings (areas).
*Emergency egress and relocation drills should have been conducted not less than monthly for a two-shift staffing arrangement, with not less than two drills conducted during the night when residents were sleeping for the entire building, not just individual wings.
*Sleeping hours were considered to be from 9:00 p.m. to 6:00 a.m. each day.
*The emergency drills could be announced to the residents in advance.
*Fire drills must involve the actual evacuation of all residents to an assembly point, as specified in

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S 295	Continued From page 24 the emergency plan, and shall provide residents with experience in egressing through all exits and means of escape. It was noted during the fire drill held on 1/17/24 at 10:30 a.m. on the second floor of the C wing (a memory care wing) that resident evacuation could be considered impractical. The drill ran for over twelve minutes. *Exits and means of escape not used in any drill shall not be credited for meeting the requirements of the Life Safety Code for board and care facilities. *All employees must be periodically instructed and kept informed to their duties and responsibilities under the plan, and such instruction shall be reviewed by the staff not less than every two months. Staff training must includethe following: orientation; annual refresher training; and participation in fire drills. The provider operated with two twelve-hour shifts with overlapping staff coverage for both shifts. *There was no documentation indicating these items were completed as required in 2023.	S 295		
S 325	44:70:04:09 Disease Prevention Each facility shall provide an organized infection control program for preventing, investigating, and controlling infection. The facility shall establish written policies regarding visitation in the various services and departments of the facility. Any visitor who has an infectious disease, who has recently recovered from such a disease, or who has recently had contact with such a disease shall be discouraged from entering the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure	S 325	During the all staff meeting, all staff were instructed by management to bring all symptoms of illness to the shift leads, and ultimately the Nurses, for evaluation on care needs and to evaluate if the symptoms constitute an outbreak. The Nurses have begun tracking any potential outbreaks and documenting the progression. The Communicable Disease outbreak policy was reviewed for any changes, and the policy was discussed in the all staff meeting. The Infection Control team will meet monthly, or more often if deemed necessary in order to evaluate the various infection control operation within the facility, and to verify responses are appropriate. Administrator or Nurse will report communicable diseases as deemed appropriate to the SD DOH.	3/4/24

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S 325	Continued From page 25 proper monitoring, tracking, and reporting of a potential infectious disease outbreak that had affected an unknown number of residents and staff. Findings include: 1. Review of resident 25's electronic medical record (EMR) revealed he: *Was sent to the emergency room (ER) on 12/30/23 with explosive watery diarrhea and associated nausea and vomiting. *Was admitted to the hospital and had tested positive for Norovirus (a highly contagious virus that causes nausea, vomiting, and diarrhea). *Was discharged from the hospital and returned to the facility memory care unit (MCU) on 1/2/24. 2. Observation and interview on 1/17/24 at 9:25 a.m. of resident 23 while in her room revealed: *She was sitting in her bathrobe with a tired appearance to her face with dark circles under her eyes. *She stated she had been suffering from nausea, vomiting, and watery yellow diarrhea for nearly a week. -There were several days she could only drink clear fluids. -She was beginning to feel better but remained very weak, and had not been out of her room in several days. *Stated the aides had been taking good care of her during this illness. *Staff had informed her that in the past few weeks nearly all the staff and residents had been ill with similar symptoms. Review of resident 23's electronic medical record revealed: *She had a Brief Interview of Mental Status of 15, indicating she was cognitively intact. *The last nursing progress note was dated on	S 325	Continued from page 25 The QAPI team will audit the Infection Control responses monthly for 90 days, then quarterly for 9 months to ensure goals are being met. The QAPI team will review Resident's documentation for changes in condition, if changes were monitored, addressed and/or reported.	

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S 325	Continued From page 26 12/8/23. *There was no documentation in her medical record indicating she had been ill in the last week or her report of symptoms as indicated above. 3. Interview on 1/17/24 at 4:00 p.m. with resident care aide (RCA) R regarding staff and resident illnesses revealed: *Today, she was assigned to work the same wing where resident 23 was located. -She was unable to recall if any residents were currently ill on the wing she was assigned. *Stated, "About three weeks ago there were a lot of staff and residents that had a stomach bug (nausea, vomiting, and diarrhea)." Interview on 1/18/24 at 9:00 a.m. with unlicensed medication aide (UMA) K regarding resident illnesses revealed: *She had been aware of several residents and staff having had nausea, vomiting, and diarrhea. -She thought it was about three residents and a few staff but was not exactly sure how many had become ill. *There had been no education provided to staff about the illness. Interview on 1/18/24 at 11:35 a.m. with registered nurse (RN) E regarding resident and staff illnesses revealed: *She was on the infection control (IC) team along with general manager (GM) B and RN D. -They had never met as a team and all IC communication was informal. *She was responsible for keeping track of disease outbreaks. -She normally tracked Covid-19, influenza, pneumonia, and tuberculosis infections among staff and residents. *In the last month or two, she thought about	S 325		

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S 325	Continued From page 27 three-quarters of the staff had been ill and was unsure how many residents had become ill with nausea, vomiting, and diarrhea symptoms. *There had been a group text sent out regarding the illness and GM B should have been aware. *She confirmed she had not tracked or monitored the illness outbreak so could not verify how many staff and residents had been affected. -She thought an outbreak would consist of about twenty to twenty-five persons, but was not sure as she had no education in that subject. *She was not aware diarrhea symptoms should have been tracked and was a reportable illness. *Administrator A was responsible for reporting disease outbreaks to the South Dakota disease reporting website. Interview on 1/18/24 at 11:55 a.m. with GM B regarding illness outbreaks and the infection prevention role revealed: *He had taken online training in infection prevention and was considered the facility's infection preventionist. *RN E and RN D were a part of his IC team. -He depended on them to inform him if there was an outbreak of illness in the facility. *He would consider an outbreak to consist of more than three persons. -Stated they had not been aware that diarrhea outbreaks were a reportable illness. *Confirmed that last month there had been a resident who tested positive for Norovirus. *During the interview with GM B, administrator A entered the room and informed they did not follow staff-reported illnesses and stated, "Staff are always calling in sick." *Administrator A stated, "There are about four staff and not many residents (that were ill)." Interview on 1/18/24 at 12:10 a.m. with RN D	S 325		

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S 325	Continued From page 28 regarding the IC team, Norovirus training, and if there was a recent facility outbreak revealed: *She had been working at the facility for about two years and was a member of the IC team. *She was the facility's staff education coordinator. *She considered all administrative staff to be a part of the IC team, however, they had not met as a team. *Stated if she were to have more than one resident with the same illness, she would be looking at a probable outbreak. -She had not been aware that diarrhea outbreaks were a reportable illness. -"I have been aware of an illness (in the facility) this past month." *No education was provided to staff about Norovirus containment. *Stated she was not confident with IC and could not recall having received any additional IC training at the facility. Interview on 1/19/24 at 12:15 p.m. with administrator A and GM B regarding disease prevention revealed: *They covered infection control and prevention issues during the quarterly quality assurance meetings. -The nurses attended those meetings. *They had been unsure about how many ill residents and staff would have been considered an outbreak. *GM B stated he had looked at the reportable disease list at least twenty times and had not seen that diarrhea was listed on the right-hand corner of the flyer. *GM B stated he would have to look at further disease prevention training and hoped to have his leadership teams trained. -He stated "Agree it needs to be greatly improved."	S 325		

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S 325	Continued From page 29 Review of the provider's 3/25/21 Communicable Disease Outbreaks policy revealed: *"Policy: The (name of facility) is required to report outbreaks of communicable diseases to the resident's power of attorney, physician, and the Department of Health." *"Procedure: If an outbreak appears to occur the Nurse or Administrator will report the outbreak to the Department of Health using the online reporting tool." *There was no documentation in the policy of how many similar infections would have been considered an outbreak.	S 325		
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, record review, and policy review, the provider failed to ensure the following: *One of one sampled resident (23) had documentation to support she had been assessed during an acute illness by a licensed nurse. *One of one unlicensed diabetic aide (UDA) P had demonstrated correct insulin administration practice for one of one sampled insulin dependent resident (20). *A diabetic skills performance assessment had been reviewed annually for one of four UDAs (P) by a licensed nurse.	S 337	All UDA staff have been given refresher training on administering insulin with a pen type delivery method by RN. All care staff will be instructed that non UDA staff are not allowed to "assist" in the use if diabetic products for residents by RN. All Medication Aides will be instructed to more carefully note injections they are documenting on, if another medical professional (i.e. MD, PA, NP) gives an injection our staff are required to document for by RN. QAPI team will spot check 3 UDA administrations per month, by RN for 90 days and quarterly for 9 months to verify compliance with UDA training. Currently TVSP management is evaluating if staff, other than licensed Nurses, are able to safely conduct post fall neuro checks that had been part of our procedure. The alternative would be to discontinue this and send all Residents to the ER for evaluation post fall.	3/4/24

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S 337	Continued From page 30 *One of one observed unlicensed medication aide (UMA) K had completed diabetic aide training before attempting to administer insulin to one of one sampled insulin dependent resident (20). *One of one resident care assistant (RCA)/UMA (Z) and one of one certified nurse aide (CNA)/UMA (AA) had not documented medication administrations that they had not administered for one of one sampled resident (30). *Two of two sampled residents' (1 and 13) physician orders for as needed (PRN) psychotropic medications included physician ordered parameters for varied doses for safe administration to those residents. *No staff other than licensed nurses had documented post-fall neurological assessments for one of one sampled resident (13). Findings include: 1. Observation and interview on 1/17/24 at 9:25 a.m. with resident 23 in her room revealed: *She was sitting in her bathrobe with a tired appearance to her face with dark circles under her eyes. *She stated she had been suffering from nausea, vomiting, and watery yellow diarrhea for nearly a week. -There were several days she could only drink clear fluids. -She stated that she was beginning to feel better, but remained very weak, and had not been out of her room in several days. *She stated that she had heart problems and took pills for diabetes and high blood pressure. *She could not remember if a nurse had visited her since she became ill, but the aides had been taking good care of her. Review of resident 23's electronic medical record (EMR) revealed:	S 337	Continued from page 30 QAPI will review UDA training and compare with staff lists at least monthly to ensure all UDA trainings are up to date. Residents with psychotropic medication orders were reviewed. PCP and Hospice physicians changed orders, discontinued orders, and/or provided additional diagnosis and parameters to ensure safety of the Resident. UMA staff were educated by Care coordinators to watch for inconsistent orders regarding psychotropic medications. GM met with Resident 23 on or about 2/15/24. Resident confirmed she does not want TVSP involved in her day to day cares. She was informed that we as a facility are required to offer care to her and that she reserves the right to change her decision at any point. Her care plan was updated to reflect this. TVSP updated the continued stay criteria with an exemption for residents who wish to remain independent in various aspects of their life. Policy, Change in condition, was reviewed and updated to reflect that anytime a staff member becomes aware of a significant change in condition, that the nurses must be notified and Resident must be proactively contacted to ensure we are meeting their desired needs. QAPI will pull 2 Resident's charts monthly and compare with data given by care staff and nursing department looking for any inconsistencies. This will continue for 12 months.	

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S 337	Continued From page 31 *She had a Brief Interview of Mental Status assessment of 15, indicating she was cognitively intact. *There had been no documented nursing progress notes since 12/8/23. *There was no documentation that she had been ill or that her heart and diabetes had been monitored during her current illness. Interview on 1/17/24 at 4:00 p.m. with resident care assistant (RCA) R revealed: *She worked at the facility five days-a-week and had been employed for the last two months. *The staff had given a report to the oncoming shift and they discussed anyone who was ill. *She was currently working on resident 23's wing. *She stated there were a lot of staff and residents who had been sick in the last three weeks with a stomach bug. -She had heard from other co-workers that it had started in the memory care unit and that someone had a bug called Norovirus. Interview on 1/18/24 at 12:40 p.m. with RCA J regarding resident 23's illness revealed: *She was standing just outside of resident 23's room door. *She was aware resident 23 had been ill since last Thursday (1/11/24). -When she started her shift two days later, it was reported to her that the nurses had been notified. -"They told me they knew (about resident 23s illness)." *The normal protocol for notifying the nurses of a resident's illness was to inform them in person. -On the weekends there was an on-call nurse they could reach if any issues arose. -The aides could document any diarrhea and they reported that during the daily end of shift report. *"The nurses do not attend shift-to-shift report."	S 337		

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S 337	Continued From page 32 Interview on 1/18/24 at 4:45 p.m. with administrator A, registered nurse (RN) D, and RN E revealed: *They stated they were unaware resident 23 had been ill for the last week. *Administrator A stated, "That's a concern. The aides should have reported it. We give them multiple tools to report illness such as notes under the door, verbally, phone calls, text messages." -She was surprised the team lead staff members had not said anything to her. *RN D stated the aides could send a high-priority message to the nurses through point-click care (PCC). -They could not locate any documentation from the aides that resident 23 had been ill or that any diarrhea had been documented. Interview on 1/19/24 at 11:00 a.m. with administrator A and general manager (GM) B regarding monitoring of resident 23's illness revealed: *Administrator A stated, "This is a tough one for me. I'm not going to triage every resident every day." *GM B stated, "We should not be required to provide medical care to independent residents. That is their decision." -Stated that unless a resident that lived independantly would request a nurse to assess them, a nurse should not be required to monitor their condition. *Confirmed resident 23 was an assisted living resident who was independent with her activities of daily living. Review of the provider's 4/15/21 Resident Change in Condition policy and procedure	S 337		

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S 337	Continued From page 33 revealed: *"Policy: Each resident of the (name of facility) is expected to maintain a substantially stable medical condition. Our facility must monitor in a general sense the condition of each resident and evaluate if that condition is stable, improving, or deteriorating or had a sudden change. If it is deteriorating, we must evaluate if this change brings about any urgent needs, and verify we can meet those needs." *"Procedures: During interactions with residents staff should be mindful of the general condition of each resident, and report any negative observations to the Care Coordinator or Nurse for further examination and/or assessment." 2. Observation and interview on 1/17/24 at 5:00 p.m. with UDA P during resident medication pass revealed: *The surveyor observed UDA P walking away from a medication cart with an insulin pen ready and the needle applied. *UDA P was asked to verbally walkthrough the initial steps of dialing up insulin into the pen. -She stated she would cleanse the port with alcohol, apply the needle, and turn the dial on the pen to the correct amount of units listed on the medication administration record. -She had not mentioned priming the needle with two units of insulin before dialing up the dosage. -She stated, "What do you mean priming the needle? I have never primed a needle. We just dial it up. No one has ever told us we needed to prime the needle. Where does it say that?" *When asked if she had diabetic aide training she stated, "Yes. I've had training. I am a diabetic." -When asked to clarify if she was UDA trained, she stated she had training at the facility. *Upon entering resident 20's room, UDA P correctly obtained a blood glucose reading,	S 337		

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cleansed resident 20's abdomen with an alcohol swab, and then gave the insulin pen to resident 20 to self-administer.
-She was unsure if resident 20 had a physician's order for self-administation.
*UDA P walked away before any further interview could be obtained.

Interview and record review on 1/17/24 at 5:20 p.m. with registered nurse (RN) D regarding the above observation revealed:
*She was the facility's UDA educator.
-She had completed the South Dakota Board of Nursing (SDBON) RN Train-the-Trainer course and provided the certificate.
-She had utilized the SDBON training manual to teach her UDA staff.
*UDA P was a UMA and had completed the UDA course on 12/30/22.
-She had passed the UDA skills portion of the exam on 12/30/22 which included a section on priming a needle with two units of insulin before dialing up the dose to have been administered from an insulin pen device.
*She was not sure when UDA P had last completed a skills exam, but she would get that information.
-She attempted to get the skills exams completed annually.

3. Record review on 1/18/24 at 11:00 a.m. of four sampled UDA's skills exam checklists revealed UDA P had not completed a skills exam in 2023.

4. Observation and interview on 1/18/24 at 11:05 a.m. with UMA K during the noon time medication pass revealed:
*She had been a UMA since November 2023.
*She removed resident 20's insulin pen and sliding scale instructions sheet from the

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S 337	Continued From page 35 medication cart and proceeded to walk to resident 20's room. -While walking to resident 20's room, UMA K verified she was not UDA trained. She stated, "Not yet, I have to plan a day with (name) RN D". *She felt a UMA was able to dial up insulin into the pen and hand it to the resident. -She had been trained by UMA Y on how to do that and had not been aware that she should have had the UDA training. -Stated, "All the UMAs do insulin." *At that point, the surveyor intervened and asked UMA K to not proceed and to seek assistance from a licensed nurse. Interview on 1/18/24 at approximately 11:15 a.m. with RN E before resident 20's insulin administration revealed: *She was employed since April 2023. *She thought all the UMAs performed glucose readings, dialed-up the dose on the insulin pen devices, and had given the pen to the residents to self-administer. -She had not administered insulin at the facility. -Stated, "It is not a common practice for nurses during the day to dial-up or administer insulin." Interview on 1/18/24 at 12:45 p.m. with RN D regarding the above observations revealed: *She was the UMA and UDA educator. *She stated, "All UMAs draw up insulin. As far as I know it's okay to draw it up, but not to inject it." -There was one resident who needed assistance with injecting insulin, otherwise all the other residents had self-administered their own insulin. *She thought those practices were covered in the UMA training and thought administration of insulin only referred to the injecting of the insulin. -She was not sure of the education specific to the UMA course, as the education was completed	S 337		

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S 337	Continued From page 36 through an online course called Educare. -She proctored the UMA testing and reviewed the skills checklists with the UMAs. *There were four UMAs who had not been UDA educated. She stated, "I'll have to train them faster." Review of the provider's 12/5/22 "SDBON Medication Aide Clinical Skills Checklist" revealed it had not included any part of glucose monitoring or administration of insulin in the skills checklist. Review of the provider's 3/25/21 Medication Administration Program policy revealed it had not included glucose monitoring or dialing up insulin into insulin pen devices as part of their policy and procedures. Review of the provider's 3/27/23 Diabetic Administration Training policy and procedure revealed: *"Policy: Medication Aides who will be assisting with Diabetic product administration or assistance for residents at the (name of facility) must undergo training conducted by the Administrator, Director of Nursing, or a Nurse prior to administering these products." *"Procedures: Medication aides are not permitted to assist in the administration of, or administer diabetic products unless they have successfully completed the (name of facility) Diabetic Administration Program. Once the program has been completed these tasks may be delegated from an RN to the Medication Aide. The skills will be re-evaluated at least annually by a Nurse." 5. Review of resident 30's electronic medical record (EMR) revealed: *A physician's order for:	S 337		

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S 337	Continued From page 37 -"Trulicity Solution Pen-injector 0.75 MG/0.5 ML. Inject 1 vial subcutaneously every Monday related to Type 2 Diabetes. (Medical Provider's name) or nurse to do once per week." -That order was started on 7/31/2023. *Her January 2024 Medication Administration Record (MAR) revealed Trulicity was documented as administered each Monday as ordered. -RCA/UMA Z documented administering the Trulicity doses on 1/1/24 and again on 1/15/24 and CNA/UMA AA documented administering the 1/8/24 Trulicity dose. *Review of the January 2024 medical provider progress notes revealed the provider documented he administered the resident's 1/8/24 Trulicity dose. Interview on 1/18/24 at 3:00 p.m. with care coordinator W regarding the above physician's order revealed only a nurse or the medical provider should have administered resident 30's weekly Trulicity injection. Interview on 1/19/24 at 12:20 p.m. with administrator A and general manager B regarding resident 30 revealed: *Medications were expected to be documented on the MAR as having been administered by the staff person who administered that medication. -A MAR progress note was expected to have been written if a medical provider administered the medication. -There was no documentation to support either a nurse or the medical provider had administered the 1/1/24 or 1/15/24 Trulicity as ordered. *Resident 30's physician order related to the administration of her Trulicity insulin was not followed. 6. Review on 1/18/24 of resident 1's EMR	S 337		

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S 337	Continued From page 38 revealed: *The following as needed (PRN) physician's orders for Trazadone (an anti-depressant and sedative): -"Trazadone oral tablet 50 mg [milligram]. Give 1 tablet by mouth as needed for sleep. May take 2 tablets at bedtime if needed." -"Trazadone oral tablet 50 mg. Give 2 tablets by mouth as needed for sleep. May take 2 tablets at bedtime if needed." *His December 2023 MAR revealed he was administered: -2 tablets of PRN Trazadone on 12/4/23 and again on 12/26/23. -1 tablet of PRN Trazadone on 12/9/23. *His January 2024 MAR revealed he was administered: -1 tablet of PRN Trazadone on 1/5/24 and 1/6/24. -2 tablets of PRN Trazadone on 1/2/24. Review on 1/18/24 of resident 13's EMR revealed: *Her diagnoses included dementia, vitamin B 12 deficiency, anemia, and a history of vaginal dysplasia. -There was no indication she had seizures. *She was receiving hospice services. *The following as needed (PRN) physician's orders for Ativan (anti-anxiety medication): -"Ativan Tablet 1 MG [milligram]. Give 0.5 tablet by mouth every 2 hours as needed for anxiety or dyspnea." -"Ativan Tablet 1 MG. Give 1 tablet by mouth every 2 hours as needed for anxiety or dyspnea." -"Ativan Tablet 1 MG. Give 1.5 tablet by mouth every 2 hours as needed for anxiety or dyspnea." -"Ativan Tablet 1 MG. Give 2 tablet by mouth every 2 hours as needed for anxiety or dyspnea." -"Ativan Oral Concentrate 2 ML [milliliter]. Give 1 ml by mouth as needed for suspected	S 337		

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seizures/hospice."
*The above orders were started on 12/29/23.
*Her January 2024 MAR revealed resident 13 was administered 1 ml PRN Ativan on 1/1/24.

Continued review of resident 13's EMR revealed:
*A 1/2/24 progress note completed by RCA BB at 9:02 p.m.:"I witnessed [resident 13] fall out of her wheelchair in the dining room and hit her head on the ground first." "She seemed a bit more disoriented than usual. She had a bruise on her head from a previous fall."
*A 1/2/24 late entry progress note documented by RN E indicated she was:
-Notified by staff of the fall referred to above: "Resident was assessed by (RCA BB) and assisted by (RCA CC), facility staff."
*Completion of a Neurological Flow Sheet was initiated after the fall and continued through 1/6/24 and included:
-An assessment of the resident's level of consciousness including her movement, hand grasps, pupil size (right and left), pupil reaction (right and left), and speech.
-Each of those areas was assigned a numeric value based upon the staff's assessment of those indicators.
*Documentation of that assessment information was completed by RCAs, CNAs, and UMAs and not licensed nurses.

Interview on 1/17/24 and again on 1/18/24 at 12:15 p.m. with registered nurse D regarding residents 1 and 13's PRN physician orders referred to above revealed:
*UMAs relied on their own judgment to have known:
-Whether to administer 1 or 2 tablets of resident 1's Trazadone.
-Which PRN Ativan order to have administered to

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S 337	Continued From page 40 resident 13. *She confirmed it was beyond the scope of practice for a UMA to have made those judgments. -It was not within a UMAs role or training to make those types of judgments. -A licensed nurse was reponsible for the oversight of UMAs and ensuring they were performing duties within their role. *If resident 13 was administered 0.5 mg, 1.5 mg, or 2 mg doses of PRN Ativan that would have required the UMA to split the 1 mg Ativan tablet or administered more than one - 1 mg Ativan tablet. -That would have been considered a "dose calculation" and that was a skill beyond the scope of practice for a UMA to perform. *RN D confirmed resident 13 had no documented seizure diagnosis and agreed "hospice" was not a symptom or a medical reason to have administered the Ativan. *RNs D and E were responsible for reviewing and initialing all physician order changes entered into a resident's EMR by care coordinators W and X. -The RN who noted the physician's orders referred to above for residents 1 and 13 was responsible for and should have contacted the ordering physician to clarify those orders. -The orders should have had specific parameters for when to give which dose if there was more than one order. *RCAs, CNAs, and UMAs did not possess the education, training, or clinical skill set to have completed neurological assessments for resident 13. Review of the provider's 2019 Registered Nurse job description revealed: *"17. Receives Physician orders and ensures they are entered into the proper systems and staff are notified of any changes."	S 337		

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S 337	Continued From page 41 *"20. Personally provides adequate supervision to all personnel working at the Village and, as necessary assists with the direct care of the residents receiving services from the care team."	S 337		
S 375	44:70:04:15 Quality Assessment Each facility shall provide for on-going evaluation of the quality of services provided to residents. 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 interview and policy review, the provider failed to identify areas requiring improvement with the facility's delivery of cares and services and to implement an effective quality assurance and performance improvement program. Findings include: 1. The following areas of deficient practices were identified during the recertification/complaint survey held from 1/17/24 through 1/19/24: *Infection control. *Disease reporting. *Resident safety. *Accommodation of resident needs/home-like environment. *Resident care. *Quality of care. *Food safety/food storage/kitchen cleanliness.	S 375	The QAPI team will meet monthly or more often as necessary to ensure the facility is continuing to meet it's goals in regards to performance for our residents. This team will actively seek out areas we are not meeting and will enact policies to ensure the goals will be met going forward. The QAPI process was reviewed, and initially QAPI met as needed. Going forward, QAPI will be scheduled as least monthly. This was explained to all QAPI members by GM. Minutes will be available after each monthly meeting to keep track of data, areas of improvements, audits and performance.	3/4/24

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S 375	Continued From page 42 *Personnel training. *Resident self-administration of medication. *Professional standards of practice. *Care plans. Interview on 1/19/24 between 11:45 a.m. and 1:15 p.m. with administrator A and general manager B regarding the areas of deficient practices referred to above revealed: *The QA team was meeting quarterly. -The team consisted of administrator A, general manager B, assistant administrator C, registered nurses D and E, care coordinators W and X, and other department heads. *Quality of care and service issues were identified through resident and family complaints/concerns, deficient practices identified during past surveys, observations made by administrator A during her "walk-throughs" of the facility, and "out of the ordinary" things brought forth and discussed during QA meetings. *Some of the areas the QA team was auditing and monitoring included: -Resident room cleanliness/sanitation on the memory care unit. -Hospice resident's care. -Staff presence on each of the three floors of the facility. *General manager B stated he "knew (about) a lot of" the deficient practices that were identified by the surveyor team. -Deficient practices related to food service were "worse than I thought." *Administrator A stated: -The focus during the first year when she and general manager B assumed management of the facility was to get the facility back into compliance after the first certification survey, increase resident occupancy, caregiver training, and improved resident care.	S 375		

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S 375	Continued From page 43 -The second year's focus was building maintenance. -The third year's focus was policy development, kitchen improvements, enhancing the facility's reputation, and providing good resident care. *"We know there are a ton of issues." Surveyor findings were "no big surprise." "I feel we've made progress." Continued interview related to administrator A and general manager B's relationship with the owners/governing body revealed: *The owners/governing body were supportive of expenditures to enhance the quality of services and care provided to residents of the facility. *Communication between administrator A and general manager B with the owners/governing body occurred no less than weekly. -"They [owners/governing body] have a good level of awareness" of what is happening within the facility. -Their primary concern was resident care: "Is anyone suffering?" Review of the provider's 5/4/21 Quality Assurance (QAPI) policy revealed: *"This facility shall have ongoing evaluation of the quality of services provided to residents. These evaluations shall include establishment of facility standards, review of resident services to identify deviation from the standards and actions to correct deviations, resident satisfaction surveys, utilization of the services provided, and documentation to report to the governing body. *The QAPI group shall meet quarterly unless there a need outlines to meet more frequently." Refer to S105, S130, S165, S201, S295, S325, S337, S375, S405, S415, S450, S685 and S835.	S 375		

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S 405	Continued From page 44	S 405		
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to develop and revise individual resident care plans to reflect the needs of five of seven sampled residents (1, 13, 14, 23, and 25). Findings include: 1. Random observations on 1/17/24 of resident 1 between 9:05 a.m. and 4:30 p.m. in the memory care unit (MCU) revealed he: *Ambulated independently throughout the common area of the unit. -Used his fingertips to feel along tabletops and other surfaces as he walked by them. *Was resistive to leaving the MCU during a fire drill. -Responded to the encouragement from an unidentified male staff member who instructed him during that fire drill. *Used plastic utensils during observed meals. *Participated in an inflatable ball toss activity. -Did not engage with other residents participating that same activity. Interviews on 1/17/24 at 10:15 a.m. and again at 12:25 p.m. with unlicensed medication aide (UMA) K regarding resident 1's behavior	S 405	The Nursing department was instructed to evaluate all care plans and ensure they are up to date and reflect the care each resident needs. It is expected that the care plans be updated when there is a significant change, in order to capture the interventions and struggles being had with each resident, and to give a much better view of the conditions. This will include family preferences, physician suggestions, and staff interventions. The Nurses will be educated on the need to frequently update the care plans with the most recent information. This was done by the Administrator. Care plans will be spot checked of 5 random care plans per month by the QAPI team for 90 days, and quarterly for 9 months unless compliance is not met. QAPI will compare known information about each Resident with what was documented in the care plan.	3/4/24

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revealed:
*He had "hit staff" but was "more calm" in the past month.
*"If he likes you, you're ok" which meant the resident was less physically aggressive towards those staff.
*She approached the resident in a calm manner during his care for the best result.
*His daughter requested relaxing "You Tube" videos be played for him to watch and/or listen to.
*His behaviors occurred most often at night.
*The resident used plastic utensils during his meals because he hoarded regular silverware in his room.

Review of resident 1's electronic medical record (EMR) revealed his:
*Admission date was 9/7/23.
-He had previously lived in the facilitys assisted living center area with his spouse.
*Diagnoses included dementia, diabetes, and anxiety.
*Progress orders included multiple medications prescribed for symptoms related to mood and behavior disorders.
-There had been several recent changes to those medications.
*Physician progress notes by his primary medical provider and a psychiatric mental health certified nurse practitioner.
*Brief Interview for Mental Status (12/8/23) score was "5" indicating he was severely cognitively impaired.
*Nurse progress notes described no less than seven instances of physical aggression towards staff or other residents between 12/1/23 and 1/17/24.
*Care plan was last revised on 12/27/23.
-It had no goals related to behavior or any behavioral intervention strategies for staff to

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S 405	Continued From page 46 follow to prevent or safely manage his aggression towards staff or other residents. Interviews on 1/17/24 at 10:15 a.m. and again at 12:25 p.m. with unlicensed medication aide (UMA) K regarding resident 1's behavior revealed: *He had "hit staff" but was "more calm" in the past month. *"If he likes you, you're ok" which meant the resident was less physically aggressive towards those staff. *She approached the resident in a calm manner during his care for the best result. *His daughter requested relaxing "You Tube" videos be played for him to watch and/or listen to. *His behaviors occurred most often at night. *The resident used plastic utensils during his meals because he hoarded regular silverware in his room. Interview on 1/18/24 at 10:15 a.m. with administrator A regarding resident 1 revealed: *The facility was soon opening an additional 16 bed MCU within the current building. -Resident 1's family had approved his move to that unit. 2. Interview on 1/17/24 at 9:45 a.m. with UMA K revealed: *Residents 13 and 14 received hospice services through the same hospice agency. *Each hospice resident had a binder provided by the hospice agency that included resident-specific hospice information. Random observations on 1/17/24 of residents 13 and 14 between 9:05 a.m. and 4:30 p.m. in the MCU revealed they were: *Assisted by staff to eat their meals in the dining	S 405		

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S 405	Continued From page 47 room. *Repositioned from their wheelchairs into recliners in the TV lounge during the course of the day. *Mostly were non-verbal and unable to engage in meaningful conversation with others. Review of resident 13's EMR revealed: *Between 1/1/24 and 1/18/24 she had four documented falls (1/1/24, 1/2/24, 1/11/24, and 1/14/24). *Her 12/1/23 revised care plan had a fall "focus" area. -Goal: "Will be encouraged to call for assistance when needed." -Interventions: "Remind to call for assistance." *Her care plan was not updated to reflect the falls referred to above or any updated fall prevention interventions based on the investigation of those falls. *Her care plan included no goals related to hospice care, no hospice-related intervention strategies for staff to follow, and no information of how the facility and the hospice agency collaborated regarding the resident's hospice care. 3. Review of resident 14's EMR revealed: *The top of page 1 of her 5/8/23 revised care plan: -"Special Instructions: MAY CRUSH ALL CRUSHABLE MEDS UNLESS CONTRAINDICATED.....HOSPICE-[HOSPICE AGENCY NAME]". *No goals related to hospice care, no hospice-related intervention strategies for staff to follow, and no information of how the facility and the hospice agency collaborated regarding the resident's hospice care.	S 405		

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S 405	Continued From page 48 4. Interview on 1/18/24 at 12:15 p.m. with registered nurse (RN) D regarding resident care plans revealed: *She or RN E were responsible for developing, updating, and revising individualized care plans for all residents annually and with any significant change in their physical or mental condition. *Caregivers referred to the care plans to know individual resident care needs and how to provide that care. *She confirmed: -Resident 1 had no behavioral care plan for caregivers to know how to effectively and safely work with him to prevent or manage his behavioral occurrences. -Resident 13's care plan had not been updated to reflect her recent falls. -Residents 13 and 14 had no hospice care plans for caregivers to have known the expectations of the facility and the hospice agency in providing those residents hospice-related care. 5. Observation on 1/17/24 at 11:49 a.m. with resident 25 in his room in the MCU revealed: *He was sleeping in his recliner with a neck pillow around his neck and a blanket over his lap. *Resident care assistant (RCA) M and certified nursing assistant (CNA) L came in with the mechanical stand aide lift to get the resident into his wheelchair (w/c) and up for lunch. *RCA M and CNA L could not wake him for lunch, so they left the resident resting in his recliner and notified the nurse. Observation on 1/18/24 at 1:35 p.m. with resident 25 in his room revealed RCA T and CNA L used the mechanical stand aide lift to get the resident from his wheelchair (w/c) into his recliner. Review of resident 25's EMR revealed he:	S 405		

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(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 405	Continued From page 49 *Was admitted to the hospital on 12/30/23 for watery diarrhea associated with nausea and vomiting. -He was tested positive for norovirus. -Returned to the facility on 1/2/24. *Had a follow-up appointment with his primary doctor on 1/3/24. -The progress note from that appointment stated the resident had a presumed case of norovirus. Interview on 1/19/23 at 9:49 a.m. with bath aide O revealed: *Resident 25 had been using the mechanical stand aide lift for toileting and transfers for the past two to three months. *She was unsure of the last time resident 25 had been able to walk to the bathroom. Review of resident 25's 8/24/23 care plan revealed: *The mobility goal was to have been able to move about the community without assistance. -The interventions were to have been independent with ambulation. *The transferring goal was to transfer safely without assistance. *The toileting goal was to toilet safely without assistance and maintain independence for toileting. -The interventions were to have been independent in toileting activities. *The care plan had not been updated related to: -The resident's use of a mechanical lift for transfers. *The resident's recent illness and hospitalization. 6. Observation and interview on 1/17/24 at 9:25 a.m. with resident 23 in her room revealed she: *Was sitting in her recliner wearing a bathrobe and had a tired appearance to her face with slightly darkened rings under her eyes.	S 405		

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S 405	Continued From page 50 *Stated she had been sick for the past week with nausea, vomiting, and liquid yellow diarrhea. *Stated, "There were a few days I could only drink clear liquids without throwing up. I haven't been out of my room for several days." -Thought she was starting to get better and the only remaining symptom was weakness. *Stated she had a history of heart issues and had been hospitalized once in the last six months related to her heart and dizziness. -She took oral medication for diabetes. *Stated she could not recall if a nurse had assessed her condition because she had been so sick. -"The aides have been taking wonderful care of me though. I didn't ask to see a nurse, so I don't think one came." Review of resident 23's electronic medical record revealed: *She had been a resident at the facility since 2019. *She had a Brief Interview of Mental Status (BIMS) of 15, indicating she was cognitively intact. *She had diagnoses of: essential hypertension (high blood pressure); atherosclerotic heart disease; diastolic congestive heart failure (CHF); dizziness and giddiness; type 2 diabetes mellitus without complications; and impaired fasting glucose. *She had a once-monthly vital signs checks and weights obtained on the seventh of every month. -There were no fingerstick blood glucose readings located in her medical record. Review of resident 23's 9/21/23 care plan revealed: *She had been independent with all activities of daily living that included: eating, bathing,	S 405		

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S 405	Continued From page 51 dressing, grooming, toileting, transferring, medication administration, bladder, bowel, activities, mobility, and home management. *There were no care plan entries addressing her chronic diagnoses of hypertension, CHF, or diabetes. -There was no mention of her recent acute illness. 7. Interview on 1/19/24 12:30 p.m.with general manager B and administrator A regarding individualized care plans revealed: *Administrator A stated the facility had been using the Point-Click Care (PCC) program to document care plans. -She thought there was not an area in the program to individualize the care plan and the plans were "very canned". *Agreed the care plans were not revised and individualized to reflect the residents needs. Review of the provider's 8/4/23 Resident Care Plan policy revealed: *"Policy: (Name of facility) utilizes "care plans" in order to govern the care for each resident. Upon admission a Nurse will generate a care plan utilizing Point Click Care. This care plan will be updated after 30 days, and at least annually thereafter. This care plan will also be reviewed and updated upon any significant change in condition of the resident. The care plan must address the medical, physical, emotional, and personal care of each specific resident[.]"	S 405		
S 415	44:70:05:03 Resident Care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and	S 415	All staff were instructed on the importance of keeping residents hand's clean prior to, and during eating times in order to ensure they are not eating with unclean hands during the all staff meeting by Management. Staff were informed that	3/4/24

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S 415	Continued From page 52 medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure effective nail care had occurred for one of one sampled resident (25) based on his individualized needs. Findings include: 1. Observation on 1/17/24 at 9:04 a.m. of resident 25 revealed: *He was sitting at the breakfast table using his right hand to pick up his breakfast food and place the food in his mouth. *His right hand had a noticeable dark brown substance underneath his fingernails. *His left-hand fingernails were yellow in color with a spotted dark brown substance under his nails. Observation on 1/18/24 at 12:30 p.m. of resident 25 revealed: *He was sitting at a dining room table with another resident. *He was eating chicken strips and tater tots with his right hand. *He was served dessert and used his right hand to grab that and start eating. *His right hand was still visibly dirty with the same dark brown substance as noticed the day before. Record review of resident 25's electronic medical record (EMR) revealed he:	S 415	Continued from page 52 individual hand sanitizing wipes were purchased for MC areas, and are expected to be used if visibly soiled hands/nails are present. Resident 25's care plan was updated to reflect his additional needs for cleaning of fingers and nails prior to meal times. Any additional Resident with known challenges in sanitary areas will be identified by care staff who will notify Nursing for care plan updates. QAPI group will conduct 4 checks on Resident 25 per month to ensure clean hands and fingernails prior to meals. This will continue monthly for 3 months, and then quarterly for the remainder of the year.	

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S 415	Continued From page 53 *Brief Interview for Mental Status (BIMS) score was 99 indicating severe cognitive impairment. *Had diagnosis of Alzheimer's disease with early onset, bipolar disorder, depressive disorder, dementia, and anxiety. *Was admitted to the hospital on 12/30/23 for watery diarrhea associated with nausea and vomiting. -Had tested positive for Norovirus. -Returned to the facility on 1/2/24. *Had a follow-up appointment with his primary physician on 1/3/24, the progress note from that appointment stated the resident had a presumed case of Norovirus. *Had a care plan with an oral hygiene goal to maintain appropriate grooming and hygiene with cueing. -Interventions had been for the resident to be independent with his personal hygiene without use of assistive devices. Review of the certified nurse assistant (CNA) nail care task revealed: *CNAs had documented they completed his nail care on 12/22/23, 12/26/23, 1/2/24, 1/5/24, 1/9/24, 1/12/24, and 1/16/24. *CNAs had documented they had not completed his nail care on 12/29/24. Interview on 1/19/24 at 9:49 a.m. with bath aide O revealed: *Resident 25 needed two-person assistance for baths. *She was one of the bath aides who had given resident 25 a bath on that previous Tuesday. *She confirmed that the resident had what appeared to be fecal matter under his nails. *She stated it was difficult to get his nails clipped and cleaned in the bath as he pulled his arm back when the bath aides were attempting to clip and	S 415		

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S 415	Continued From page 54 clean his nails. *She felt he was difficult and the bath aides were doing the best they could to clean his fingernails. Interview on 1/19/24 at 11:30 a.m. with administrator A revealed: *They have had multiple discussions with the wife on what could be done to clean his nails. *They felt it was a battle for the staff as the resident had not let his wife assist with cleaning his nails at home. *She stated resident 25 had been digging into his bowel movements (BM) daily. *She agreed the CNAs should not have been documenting they had performed nail care if it had not been done. Review of the provider's 3/15/21 Resident Care Policy revealed "Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing and body clean and healthy."	S 415		
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. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow their policy to ensure food items were appropriately sealed, labeled, and dated to ensure food safety in the following areas:	S 450	All dietary staff will be instructed on the requirements to properly label, date, and seal food items in order to minimize the chance that bad food is served to a resident by Assistant Administrator or Dietary Manager. All unlabeled, undated and unsealed items were corrected. Assistant Administrator or dietary manager have throughly inspected kitchen and food storage areas to ensure no remaining food was unlabeled, undated and unsealed. No policy revision was necessary as the non-compliance was rooted in poor enforcement of guidelines.	3/4/24

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S 450	Continued From page 55 *One of one stand-up combination refrigerator-freezer unit. *One of one cooking preparation table. *One of one storage shelf. *One of one walk-in freezer. *One of one memory care unit (MCU) galley. *One of one MCU dining room during one of one observed breakfast meal. Findings include: 1. Observation and interview on 1/17/24 at 9:05 a.m. with assistant administrator F in the kitchen revealed: *The stand-up combination refrigerator-freezer unit contained food items on the refrigerator side that had been opened, but had no open date written on them. That included the following items: -Gallon jugs of cocktail sauce, pickles, relish, ranch dressing, banana peppers, and three jugs of barbecue sauces. *A bag of shredded cheese, a plastic container of pickles, and an eight ounce container of milk. *The stand-up combination refrigerator-freezer unit contained food items on the freezer side that were not sealed or labeled. That included the following: -Bags of pancakes, french toast, chocolate muffins, hash browns, french fries, onion rings, potato wedges, beef patties and tater tots. *The cooking preparation table in the kitchen had food items that were not sealed or labeled. That included the following items: -A bag of dried brownie mix, an unidentified bag of white powder, two bags of instant mash potatoes, a bag of brown sugar, and pork and beef gravy mix. -There were season packets of coconut powder, curry powder and two packets of taco seasoning. *The storage shelf across from the cooking	S 450	Continued from page 55 Assistant Administrator or dietary manager will conduct audits to ensure correct labeling, dating, and sealing weekly for 2 months, and then monthly thereafter for the remainder of the year.	

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S 450	Continued From page 56	S 450		

preparation table in the kitchen had food items that had been opened with no label. That included the following items:
-An unsealed box of elbow macaroni and rotini pasta.
-Plastic storage container with two different types of nuts, an unidentified white powder, and unidentified black crumbs.
*Assistant administrator F was responsible for the oversight of the kitchen.
-She agreed that the above items should have been sealed, labeled, and had open dates on them.
-Kitchen manager G was responsible for making sure that the food items were sealed, labeled, and dated.

Observation and interview on 1/18/24 at 4:35 p.m. of the walk-in freezer with kitchen manager G revealed:
*An unsealed bag of what appeared to be frozen garlic bread and tortilla shells with no label or date on them.
*Kitchen manager G was not aware that food items needed to have been sealed, labeled, or dated after opening them.

Interview on 1/19/24 at 12:53 p.m. with administrator A and general manager B revealed:
*Assistant administrator F was responsible for the oversight of the kitchen.
*They agreed that food should have been sealed, labeled, and dated after opening according to their policy.

2. Observation and interview on 1/17/24 at 9:30 a.m. with resident care assistant V in the MCU galley revealed:
*Stacks of single-serving dry cereal cups and a plastic tote full of single-serving oatmeal packets

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S 450	Continued From page 57 that had been removed from their original packaging. -There was no date on the individual packages how long those food items were safe to consume. *Both food items were offered to residents as options during snack passes. -She assumed the food products stocked in the galley were safe for resident use. 3. Observation on 1/18/24 between 8:35 a.m. and 9:15 a.m. in the MCU dining room revealed: *Rows of uncovered cups filled with nutritional supplements on top of a wheeled cart. -The cart was positioned behind staff assisting residents to eat and in front of an empty dining table. *Cups were removed from the cart by staff and offered to residents throughout the meal service. *Ambulatory residents walked by the cart throughout the meal service touching the top of the cart or setting unclean items on it. *Three unused cups remained on the cart at the end of the observation period referred to above and were discarded by staff. Interview on 1/19/24 at 12:01 p.m. with administrator A and general manager B regarding food storage revealed: *Care coordinators W and X were responsible for checking the food products in the MCU galley weekly for proper storage, labeling, and the removal of outdated food products. -This was a food safety concern. *The supplements referred to above should have been covered after preparing them to lessen the risk of contamination. Review of the provider's 5/3/21 Food Safety policy revealed: *"Dietary staff shall label any opened	S 450		

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S 450	Continued From page 58 item/bag/container, with what the item is, the date it's been opened and expiration date." *"Dietary staff shall properly seal any opened item/bag/container with some type of clip, band or seal to ensure the item is not exposed to bacteria."	S 450		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. 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: *Two of three insulin dependent sampled residents (20 and 30) who self-administered their insulin had been screened to safely self-administer that medication. *Three of six sampled residents (23, 24, and 31) who had a self-administration of medication physician's order had been screened every three	S 685	Nurses were given direction by Administrator to evaluate all medication self administration residents every 90 days, or more often if needed to ensure they are in fact capable of safely self administering their medications (including diabetic medications). Nursing staff were asked to complete the medication self administration assessments for resident 20, 23, 24, and 31. Nursing completed any outstanding medication administration self assessments. This was verified by Administrator. All care staff will be instructed on the separating between self administration and facility administration of medications and that non UDA staff cannot "assist" in administration of diabetic products. Staff will be instructed by Nurses or Care coordinators to report any issues found with residents self administering medications directly to Nurses. Both Nurses have been directed to share the assessment duties in order to eliminate any extended absences. Nurses were instructed by GM to verify which residents are Self Administer prior to stating to DOH representatives that certain residents are self administer as resident 30 is not self administer. QAPI group will review all Self medicating Residents every 90 days to ensure compliance. Findings will be gone over in the QAPI meeting every 3 months. This will include any new Resident who has a self administration order, and those who may no longer meet that requirement. QAPI committee will pull electronic software reports every 3 months.	3/4/24

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S 685	Continued From page 59 months to determine safety in the administration of those medications. Findings include: 1. Observation on 1/17/24 at 11:30 a.m. with unlicensed medication aide (UMA) K in resident 20's room revealed: *UMA K dialed up a dose of insulin in an insulin pen device, and after rubbing an alcohol pad on the resident's abdomen, she handed resident 20 her insulin pen. *Resident 20 administered the insulin into the upper center of her abdomen. -Resident 20 told UMA K that she could not see if she had given herself all of her insulin and asked UMA K to verify the pen was empty. 2. Observation and interview on 1/17/24 at 5:00 p.m. with UMA P in resident 20's room revealed: *UMA P dialed up a dose of insulin into an insulin pen device, and after rubbing an alcohol pad on the resident's abdomen, she handed resident 20 her insulin pen. *Resident 20 administered the insulin into the upper center of her abdomen. -That was the same area that was observed for administration at 11:30 a.m. -Resident 20 told UMA P that she could not see if she had given herself all of her insulin and asked UMA P to verify the pen was empty. *UMA P was not sure if resident 20 had a self-administration physician order for that insulin. Interview on 1/17/24 at 5:20 p.m. with registered nurse (RN) D regarding the above observations revealed: *She stated all the insulin-dependent diabetic residents, except one, had self-administered their own insulin. -She identified residents 20 and 30 as	S 685		

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S 685	Continued From page 60 self-administering their insulin. Review of residents 20 and 30's electronic medical record revealed they had no medication self-administration safety screens performed by a licensed nurse. A request was made on 1/18/24 at 10:00 a.m. to care coordinator X for a list of the residents that had self-administered their medications along with a copy of the past twelve months of their medication self-administration safety screens. A list of six residents and their safety screens were provided. 3. Review of residents 23, 24, and 31's Medication Self-Administration Safety Screens revealed: *Resident 23 had safety screens performed on 9/20/22, 5/19/23, 9/21/23, and 12/21/23. -That included a period of eight months and a period of four months without a licensed nurse performing a screening. *Resident 24 had safety screens performed on 10/4/21, 9/20/22, and 12/21/23. -That included a period of eleven months and a period of one year and three months without a licensed nurse performing a screening. *Resident 31 had safety screens performed on 7/27/23 and 1/17/24. -That included a period of nearly six months without a licensed nurse performing a screening. Interview on 1/18/24 at 12:45 p.m. with RN D revealed: *She had been employed with the provider for nearly two years. *She was responsible for conducting medication self-administration screenings for residents who self-administered medications.	S 685		

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S 685	Continued From page 61 -She had been away on an extended leave and was trying to catch up with those resident medication safety screenings. Interview on 1/19/24 at 11:30 a.m. with administrator A and general manager B regarding medication self-administration screenings revealed they were not aware the screenings had not been completed on time. Review of the provider's 4/11/21 Medication Self Administration policy revealed: *"Policy: Residents of the (facility name) have the right to administer their own medications as long as they are able to do so safely." *"Procedures: Should a resident request to "Self Administer" medications, a Nurse must utilize the Medication Self Administration Assessment in Point Click Care to verify the resident is capable. Once the resident is evaluated the determination should be noted in the record." *There was no information about conducting those medication safety screenings every three months. Review of the provider's 3/15/21 Resident Care policy revealed, "Policy: The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed..."	S 685		
S 835	44:70:09:09(1) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including:	S 835	All care staff were instructed on the importance of cleaning wheelchairs and similar equipment in order to ensure sanitary conditions are maintained.Staff were also educated on the importance of silverware, table height and room access. This was done during the all staff meeting by TVSP management.	3/4/24

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	67721	A. BUILDING: _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT SKYLINE PINES	1050 FAIRMONT BLVD RAPID CITY, SD 57701

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S 835	Continued From page 62 (1) A safe, clean, comfortable, and homelike environment; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to provide care and an environment that contributed to the resident's quality of life in the memory care unit (MCU) by failing to ensure the following: *Environmental accommodations were made for one of one sampled MCU resident (9) during two of two observed meal services. *MCU residents' plates were not visibly labeled with their names. *Two of two sampled MCU residents (8 and 32) wheelchairs were maintained in a sanitary manner. *Two of two shared resident toilets in the MCU bathrooms were promptly cleaned after use by three of three sampled residents (5, 6, and 11). *One of one observed MCU resident (7) was allowed access into her locked room promptly. Findings include: 1. Observation on 1/17/24 at 9:15 a.m. of resident 9 in the MCU dining area eating breakfast revealed: *The edge of the dining room table that she sat in front of was just about level with her chin. -Dining room table height varied by about 2-3 inches depending upon whether the metal pieces under a tables legs were extended or not. Continued observation and interview on 1/17/24 at 12:10 p.m. with resident 9 revealed she: *Again sat at a dining room table that was at a height that had not allowed her to comfortably rest her arms on top of the table.	S 835	(Cont from page 62) Care Coordinators and Nurses were instructed by GM that they will be expected to look for opportunities to better Resident's quality of life and bring it to the monthly QAPI meetings. One table in each MC area will be lowered 6 inches for Resident 9 and any other identified Residents requiring such accommodations. Names were removed from dining plates in the MC units. During the all staff meeting, all staff were instructed by management team, to be more vigilant towards Residents and their needs to enter their rooms. Cleaning of wheelchairs was added to overnights cleaning checklist while Residents were not using them. Care Coordinators will spot check once a week to ensure Resident 9 is eating at the lower table and that wheelchairs and other toilets in MC are sanitary. This will be done weekly for 3 months, and then quarterly thereafter . These findings will be gone over at each monthly QAPI meeting by QAPI members and documented.	

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S 835	Continued From page 63 -Used her right hand to hold her eating utensil while holding her cupped left hand underneath it to catch food that risked falling off the utensil. *Stated "This is ridiculous" when asked about the height of the table and her inability to comfortably eat her meals. 2. Observation and interview on 1/17/24 at 9:25 a.m. with resident care assistant (RCA) S in the MCU dining area revealed: *Residents able to feed themselves were served their breakfast on plates that had their first names written in black marker on them. -That was so new staff had known which plated food belonged to which resident. 3. Observations on 1/17/24 at 12:10 p.m. and on 1/18/24 at 8:35 a.m. in the MCU dining area revealed: *The metal frame inside that supported the wheels of resident 8's Broda wheelchair and the metal crossbar between the wheels were coated with a dried, tan-colored, substance. *The metal frame that supported the wheels of resident 32's wheelchair was coated with an unknown dried substance. 4. Random observations on 1/18/24 between 8:00 a.m. and 9:15 a.m. in the MCU dining area revealed: *Residents who arrived for breakfast after 8:35 a.m. were provided plastic eating utensils for use during that meal. -Residents who arrived before that time received stainless steel silverware to use. *There was no extra silverware in the MCU galley or on the transport cart that brought the breakfast meals. -Neither kitchen staff nor caregiver staff who assisted during that breakfast meal were	S 835		

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S 835	Continued From page 64 observed attempting to locate silverware for those late arriving MCU residents to have used. 5. Random observations on 1/17/24 between 9:20 a.m. and 4:15 p.m. and again on 1/18/24 at 8:30 a.m. of the two shared resident bathrooms in the MCU revealed: *At 9:20 a.m. the south hall shared resident bathroom had bits of paper towels on the floor, spatters of brown feces inside the toilet bowl, and dried urine on the outside of the toilet bowl. *At 10:30 a.m. RCA M unlocked the bathroom door and allowed resident 5 inside to use the bathroom. -At 4:15 p.m. an unidentified resident exited the bathroom. -The bathroom remained unclean in the manner described above on 1/18/24 at 8:30 a.m. *At 9:25 a.m. the shared resident bathroom located in the whirlpool room had spatterings of brown feces inside of the toilet bowl. -At 11:15 a.m. RCA S exited the bathroom with resident 6. -At 11:20 a.m. RCA V exited the bathroom with resident 11. Interview on 1/17/24 at 12:01 p.m. with RCA V regarding the observations referred to above of the shared resident bathroom in the whirlpool room revealed she: *Was not aware of the fecal spatterings inside of the toilet bowl when she had taken resident 11 to use that bathroom otherwise she would have cleaned it. -There were disinfectant wipes, a toilet bowl brush, and toilet bowl cleaner in the whirlpool room for staff to use if needed. 6. Observations of resident 7 in the MCU revealed:	S 835		

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S 835	Continued From page 65 *On 1/17/24 from 10:20 a.m. through 10:30 a.m. she paced between her room and the MCU dining room. -Each time she reached her room door she stopped and repeatedly tried to open the door but the door was locked. -She attempted to open the door of the resident's room next to hers when she was unable to open her own room door. *She was unable to verbalize to staff her desire to go into her room. *When RCA M noticed resident 7 attempting to open her room door, he unlocked the door, and let her inside of her room. *On 1/18/24 from 3:37 p.m. through 4:30 p.m. she paced between her room and the MCU dining room. -Each time she reached her room door she stopped and repeatedly tried to open the door but the door was locked. -No staff offered or assisted the resident inside of her room. Interview on 1/18/24 at 4:30 p.m. with RCAs I and S regarding resident 7 revealed: *Both RCAs were recently hired and had little experience working with residents who had dementia. *RCA I had known residents' room doors were locked to prevent residents from wandering into each other's rooms. -She thought residents had keys to their own rooms. *RCA S knew residents did not have keys to their own rooms. *She saw the resident trying to get into her room that afternoon: "She's always doing that." -Stated "I don't know why" when asked why she had not allowed the resident in her room.	S 835		

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S 835	Continued From page 66 7. Interview on 1/19/24 at 11:30 a.m. with administrator A and general manager B regarding the observations referred to above revealed: *Inappropriate table height, labeled dining plates, plastic utensils, and uncleaned mobility devices prevented all MCU residents from experiencing a comfortable and dignified dining experience. *Staff were expected to recognize and provide residents prompt access inside their rooms. *It was expected that caregivers and housekeeping staff worked together to ensure the bathroom cleanliness following resident use. Review of the provider's 4/1/21 Resident Quality of Life policy revealed: *"Each resident of the Village at Skyline Pines is entitled to the very best quality of life we can provider. Every staff member regardless of department has a primary directive of improving the quality of life for each resident." *"Each resident has specific needs, and our staff are expected to accommodate those needs to the best of their ability, while respecting the dignity and well being of the resident."	S 835		

South Dakota Department of Health

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{S 000}	Compliance Statement An onsite and phone revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 3/21/24 and again on 4/9/24, for all previous deficiencies cited on 1/19/24. The Village at Skyline Pines was found in compliance.	{S 000}		

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