PRINTED: 12/12/2023
FORM APPROVED

South Dakota Department of Health

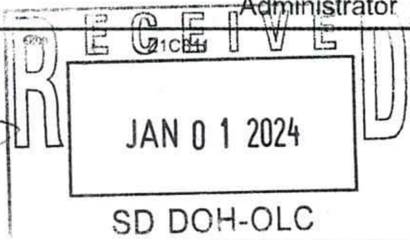
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42874	A. BUILDING ______ B. WING ______	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING	600 S HILL ST SALEM, SD 57058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/28/23 through 11/29/23. Leisure Living was found not in compliance with the following requirements: S150, S169, S201, S215, S280, S381, S400, S503, S506, S621, S642, S680, S685, and S800. 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 11/28/23 through 11/29/23. The areas surveyed were: food and other supplies, sanitation, and the facility's environment. Leisure Living was found in compliance.	S 000		
S 150	44:70:02:13 Lighting Any space occupied by people, machinery, and equipment within buildings and their approaches and parking lots shall have artificial lighting at a level for general safety. Each resident bedroom shall have general lighting and night lighting. A reading light shall be provided for each resident who can benefit from one. Each required exit shall be equipped with continuous emergency lighting. Emergency power shall be provided if the main source of power fails. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and testing, the provider failed to maintain one randomly observed emergency lights (south wall	S 150	Emergency light on the south hall of living area was replaced 12/12/2023. Administrator or designee will monitor emergency light weekly for three weeks and monthly for 12 months.* CKH Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *Emergency lights will be added to the preventative maintenance checklist.	1/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/22/2023

STATE FORM | 21C811 | If continuation sheet 1 of 31



1/1/24

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S 150	Continued From page 1 of living area) as required as part of a preventative maintenance plan. Findings include: 1. Observation and testing on 11/29/23 at 11:14 a.m. revealed the emergency light on south wall of living area was not functioning when tested. Interview with the administrator designee D at the time of those observations confirmed that finding. Record review of the facility's preventative maintenance plan that same day revealed there was no documentation of the required monthly thirty-second tests or the annual ninety-minute test for emergency lights.	S 150		
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, interview, and record review the provider failed to maintain an electrically activated audible alarm on three of four exit doors. (main entrance, south wing exit, and north exit) Findings include: 1. Observation and testing beginning on 11/29/23 at 12:10 p.m. revealed the unattended main entrance to the building (west door) was equipped with a door alarm but it did not sound when the	S 169	Director educated all staff on door alarms and reviewed occupant protection policy on 12/14/2023 Director or designee will monitor door alarms nightly for 7 nights and then one time a week for three weeks and then monthly for 12 months. Administrator or designee will present findings from these audits at the monthly QA committee for review.	1/13/2024

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S 169	Continued From page 2	S 169		

door was opened.
That same condition was also found on the south and the north wing doors.

Interview and testing with the administrator designee D at 1:27 p.m. that same day revealed the building's door alarm was outside of the administrator office and did function correctly when tested for each of the doors but had been placed into the "Off" position. She stated the facility although it was licensed for residents with cognitive impairments did not have any residents who would meet the requirements for being assessed as being cognitively impaired.

This deficiency had the potentially affect all residents of the facility with cognitive impairment. Random observations on 11/28/23 between 11:45 p.m. and 4:30 p.m. and again on 11/29/23 between 10:15 a.m. and 3:45 p.m. revealed:
*Residents 5 and 6 had propped open the back door of the facility.
*The residents were outside at the smoking area just outside of that opened, unattended, and unalarmed exit door.
*They were alone, with their coats on, sitting on their wheeled walker seats.
*Resident 5 was smoking cigarettes and resident 6 was smoking a pipe.

Review of the facility's resident's Brief Interview for Mental Status (BIMS) scores for current residents revealed:
*Three residents had a BIMS score of 6 indicating they had severe cognitive impairment.
*One resident had a BIMS score of 8, four residents had a BIMS score of 9, one resident had a BIMS score of 10, and one resident had a BIMS score of 12 indicating they had moderate cognitive impairment.

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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 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: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 11/29/23 at 2:45 p.m. revealed there was no documentation of fire drills being conducted for any shift during quarter one (January, February, March) or quarter three (July, August, September) in 2023. Interview with the administrator designee D at the time of the record review confirmed those findings. She stated she was unaware the minimum number of fire drills per the required frequency had not been met for each shift for 2023 as she had just stared helping at the facility in the past few months. The deficiency had the potential to affect 100% of the occupants of the building.	S 201	Director reviewed Fire Drill policy and has been educated on the requriements. *CKH Leisure Living Salem will perform audits on fire drills rotating each shift monthly. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *Director will be responsible for ensuring fire drills are completed monthly and quarterly for each shift. CKH	01/13/2024
S 215	44:70:03:03 Fire Extinguisher Equipment	S 215		

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S 215	Continued From page 4 Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain two randomly observed fire extinguishers (north wing and kitchen) as required as part of a preventative maintenance plan. Findings include: 1. Observation on 11/29/23 at 12:26 p.m. revealed the fire extinguisher in the south wing was missing monthly inspections recorded on the fire extinguisher service tag for the months of May, June, and July, 2023. 2. Observation on 11/29/23 at 12:38 p.m. revealed the fire extinguisher in the north wing was missing monthly inspections recorded on the fire extinguisher service tag for the months of September 2023 and October 2023. Interview with the administrator designee D at the time of the observations confirmed those findings.	S 215	Director has reviewed the fire extinguisher equipment requirements. Administrator or designee will monitor all fire extinguishers in the building monthly. Monthly checks added to preventative maintenance. Administrator or designee will present findings from these audits at the monthly QA committee for review.	01/13/2024

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S 215	Continued From page 5 This deficiency could potentially affect all residents of the facility.	S 215		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and job description review, the administrator failed to manage the facility in a manner that ensured the overall daily management of the facility, appropriate resident care, resident safety, and maintained compliance with the Administrative Rules of South Dakota (ARSD) 44:70 Assisted Living Center regulations. Areas of concern included the following: *Occupant protection related to door alarms and resident with cognitive impairment. *Emergency lighting. *Fire safety equipment. *Personnel training. *Discharge planning for residents. *Nursing policies and procedures related to tobacco use. *ServSafe certification of the dietary manager and one cook. *Dietary inservice training. *Drug regimen reviews.	S 280	Director has been registered for South Dakota Assisted Living administrator course through Relias Academy 12/18/2023. Director will work on the completion of the course.* CKH Administrator will oversee director as director completes the course. Administrator or designee will present findings at the monthly QA committee for review until the QA committee advises to discontinue monitoring. * The projected date of completion for the course will be 60 days from registering, or 2/16/24. CKH	01/13/2024

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S 280	Continued From page 6	S 280		

*Documentation processes of medications for discharged residents.
*Having prescription medications available without proper labeling according to physician orders and requirements.
*Processes for self-administration of medications.
*Notification of physician of resident condition changes.
Findings include:

1. Interview on 11/28/23 at 11:05 a.m. with director A revealed:
*She thought she was the administrator.
*She was hired on 9/5/23.
*She was responsible for oversight and daily operations of the facility.

Interview on 11/29/23 at 12:57 p.m. with director A revealed:
*Her position was not the administrator.
-She was the director.
*She had seen administrator C once in October 2023 and once November 2023 for a "hour or two each time".
-He was her supervisor.
*She had requested to take the South Dakota Assisted Living Center Administrator's course and had not received approval.
*She was aware of the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers requirements for assisted living centers.
*Administrator designee D was her preceptor.
-Administrator designee D was available by phone and came to the faciliy once a week to deliver food for the residents.

A message was left on 11/29/23 at 4:19 p.m. on administrator C's telephone voice mail, no call was returned by the end of the survey.

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S 280	Continued From page 7 Refer to S150, S169, S201, S215, S381, S400, S503, S506, S621, S642, S680, S685, and S800.	S 280		
S 381	44:70:04:16 Discharge Planning The facility shall initiate planning with applicable agencies to meet identified needs, and a resident must be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care must be made available to whomever the resident is discharged and to each referral agency as provided by the discharge plan. This Administrative Rule of South Dakota is not met as evidenced by: Discharge Planning Based on closed care record review, interview, and policy review, the provider failed to ensure one of one discharged resident (7) had discharge planning developed before he discharged from the facility. Findings include: 1. Review of resident 7's closed care record revealed: *He was admitted on 7/26/23. *He was discharged to his home on 10/28/23. *There was no documentation to support a discharge plan had been developed for him. Interview on 11/29/23 at 12:22 p.m. with director A regarding discharge planning for residents revealed: *She was not aware discharge planning was required. *She confirmed there was no documented discharge planning for resident 7.	S 381	Director has reviewed discharge planning policy. * CKH Director has implemented the discharge planning paperwork in all residents chart on 12/1/23. All residents will be evaluated at the time of entrance, 30 days and annually. Administrator or designee will implement Discharge Planning paperwork with any new residents going forward. Administrator or designee will audit weekly for four weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *Director, licensed nurse, and any other staff responsible for discharge planning process will be re-educated by the Administrator or designee. CKH	01/13/2024

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S 381	Continued From page 8 *There were no discharge plans for any of the current residents. Review of the provider's 2017 Discharge Planning policy revealed: *"Discharge planning will begin for every resident at the time of admission. This facility will not harbor any resident who requires a higher level of care that can be provided to them. -"Discharge planning will also be a part of each resident's care plan." -"All information necessary for the coordination and continuity of care will be provided to whichever agency or agencies that the resident is discharged to."	S 381		
S 400	44:70:05:01 Nursing Policies And Procedures The facility shall establish and maintain policies and procedures that provide nurses and other healthcare personnel with methods of meeting the facility's administrative and technical responsibilities in providing care to residents. The policies must include: (1) The noting of diagnostic and therapeutic orders; (2) The assignment of the nursing care of residents; (3) Administration and control of medications; (4) Assessment and documentation by nurses; (5) Documentation by healthcare personnel; (6) Infection control; (7) Resident safety; (8) Delineation of orders from nonphysician practitioners; and (9) Activities of daily living to maintain each resident's physical functioning and personal care.	S 400	Director reviewed and revised as necessary the smoking policy. Director reviewed the revised policy with current residents who smoke and educated the staff on updated policy. Smoking assessments will be completed by Administrator or designee or nurse consultant upon admission and quarterly on residents who smoke. Administrator or designee will audit weekly for four weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring.	01/13/2024

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S 400	Continued From page 9 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 follow their tobacco use policy for two of two sampled residents (5 and 6) to ensure the resident's safety for the following: *Assessments being completed upon admission and quarterly for all residents who used tobacco. *Storage of tobacco use materials. *Designated smoking times and use of the exit doors. Findings include: 1. Random observations on 11/28/23 between 11:45 p.m. and 4:30 p.m. and again on 11/29/23 between 10:15 a.m. and 3:45 p.m. revealed: *Residents 5 and 6 had propped open the back door of the facility. *The residents were outside at the smoking area just outside of that opened, unattended, and unalarmed exit door. -Residents living in the facility with cognitive impairment would have had the ability to leave the facility without staff being aware. *They were alone, with their coats on, sitting on their wheeled walker seats. *Resident 5 was smoking cigarettes and resident 6 was smoking a pipe. 2. Observation and interview on 11/28/23 at 12:40 p.m. with resident 5 revealed she: *Wore oxygen at all times except for when she went outside for a cigarette. *Reported she was able to turn the oxygen concentrator off and on and put the nasal cannula on herself. *Kept cigarettes and a lighter in her room and	S 400		

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S 400	Continued From page 10	S 400		

was able to go outside independently with her walker when she wanted to smoke.

Review of resident 5's care record revealed:
*She was admitted on 11/1/23.
*She had a BIMS score 15 of indicating she was cognitively intact.
*Her diagnoses included chronic obstructive pulmonary disease, hypoxia, which is low levels of oxygen in the body, and emphysema.
*She had a physician order and assessment to self-administer her oxygen.
*A smoking assessment was completed, documented, and signed by her that she understood the rules of smoking for this facility on 11/1/23.

3. Observation and interview on 11/28/23 at 3:40 p.m. with resident 6 in his room revealed he:
*Was sitting in his recliner watching TV with a walker next to his recliner and an oxygen concentrator next to his bed.
*Moved to the facility due to falls at home and his doctor and son did not feel he was safe at home.
*Used a walker to ambulate and he had fallen outside the facility twice.
*Wore oxygen at night when he slept and was able to put the nasal cannula on himself, but staff were available and helped him.
*He smoked a pipe and, kept his pipe, tobacco, and lighter in his room.
*He was able to go outside independently with his walker when he wanted to smoke.

Review of resident 6's care record revealed:
*He was admitted on 7/28/23.
*He had a BIMS score of 14 indicating he was cognitively intact.
*His diagnoses included vascular dementia with behavioral disturbance.

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*He had a physician order to use oxygen at bedtime.
*A smoking assessment was completed, documented, and signed by him that he understood the rules of smoking for this facility on 10/6/23.
-That was over two months after he had been admitted.

4. Interview on 11/29/23 at p.m. with director A regarding the facility tobacco use policy revealed:
*She was hired on 9/5/23.
*There were four residents at the facility who smoked.
*Residents who smoked should have been assessed for safe smoking when they were admitted and quarterly.
*She was responsible to have completed resident smoking assessments since hired.
*She had not known who was responsible to complete resident smoking assessmennts before she started working at the facility.
*One resident's tobacco was kept in her office, the other three residents kept their tobacco in their rooms, and all residents had their own lighters.
-That had not been done according to their policy.
*Residents had been informed and were aware of the designated smoking times, but they went outside to smoke on their own as they chose and didn't follow the designated smoking times according to the policy.
*She confirmed:
-Resident 6 had not had a smoking assessment completed when he was admitted and he should have.
-Residents were leaving the back door to the designated smoking area open when they were outside smoking.
-They were not following their facility tobacco use

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S 400	Continued From page 12 policy overall and this posed a risk for resident's safety. Review of the provider's undated "Policy on Tobacco use in Leisure Living Salem" revealed: *"Purpose: To ensure safe tobacco use for all residents of Leisure Living Salem *All residents at Leisure Living Salem have the right to use tobacco under the following conditions:" -"2. All residents will be assessed for their safety upon admission by the manager/administrator or designee." -"6. Residents who choose to smoke must smoke away from the door to allow the door to be utilized." -"9. All tobacco material [i.e., cigarettes, matches, lighters, smokeless cigarettes, chewing tobacco] will not be allowed to be kept in the resident's room. All tobacco material will be kept locked up and dispensed by the nurse. Upon request, tobacco material will be given to the resident." -"10. Tobacco material will not be allowed to be carried by the resident within the facility except from the nurse's station to the designated smoking area. All tobacco material must be returned to the nurse upon return into the facility." -11. If resident's O2 sats (oxygen saturation) are below 90%, they will not be allowed to smoke until they are above this range." -"12. Tobacco times: 4 times a day 6:30/7:00 A.M. ---10:30 A.M./11:30 A.M. --- 1:30 P.M./2:30 P.M. --- and 6:30 P.M./7:00 P.M. May be adjusted based on nurse availability."	S 400		
S 503	44:70:06:16 Person In Charge Of Dietary Services The person in charge of dietary services shall	S 503		

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S 503	Continued From page 13 possess a current certificate from: (1) A ServSafe Food Protection Course; (2) The Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association; or (3) Equivalent training as determined by the department. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and policy review, the provider failed to ensure the dietary manager and at least one employed cook had completed and possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 11/29/23 at 12:22 p.m. with director A regarding employee ServSafe training revealed: *She was hired on 9/5/23. *She was in charge of the dietary department. *She was not ServSafe Food Protection Program certified. *She thought administrator designee D was ServSafe certified. *There was no other staff working on-site that was ServSafe certified. Interview on 11/29/23 at 2:48 p.m. with administrator designee D revealed: *She was not ServSafe Food Protection Program certified. *There was no other staff that was ServSafe Certified that was working in the facility. *There was no policy regarding ServSafe certification requirements for employees.	S 503	Facility has implemented a ServSafe nutritional needs policy on 12/21/2023. Medication Aide/Cook has been registered for ServSafe course on 12/22/2023 through ServSafe online. Medication Aide/Cook will be proctored for testing when course is completed.* CKH Administrator or designee will audit progress of completion of the ServSafe course. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. CKH *The projected completion date for the Director on the servsafe course will be 60 days from registration, or 2/20/2024.	01/13/2024

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S 506	Continued From page 14	S 506		
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel training records, interview, and policy review, the provider failed to ensure four of four sampled employees (E, F, G, and H) had received ongoing dietary inservice training on the following topics: food safety, food handling/preparation, serving and distribution procedures, and leftover food handling policies. Findings include: 1. Review of employee personnel training records revealed: *Employee E was hired on 5/28/22. *Employee F was hired on 7/13/18. *Employee G was hired on 7/2/21. *Employee H was hired on 11/4/22. *There was no documentation to support the	S 506	Director performed the required dietary inservice training with all staff on 12/06/2023. Reviewed the requirements of; food safety, handwashing, food handling and preparation techniques, food borne illnesses, serving and distribution processes, leftover food handling, time and temperature controls for food preparation and service, nutrition and hydration and sanitation requirements. The administrator or desginee will monitor the completion of all new hires to ensure the completion of dietary training is completed within 30 days as well as annually for all staff. * CLH Administrator or designee will audit for four weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. * New hire required training will be documented in the employee's file. Annual required education will be recorded in an education binder. CLH	01/13/2024

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S 506	Continued From page 15 employees listed above had received ongoing dietary inservice training on the following topics: food safety, food handling/preparation, serving and distribution procedures, and leftover food handling policies. Interview on 10/29/23 at 9:08 a.m. with director A revealed: *She confirmed there was no documentation to support the above dietary training had been completed. *There was no policy regarding training of employees.	S 506		
S 621	44:70:07:03 Medication Therapy Reviewed Monthly The pharmacist shall report potential drug therapy irregularities and make recommendations for improving the drug therapy of the resident to the resident's physician, physician assistant, or nurse practitioner, the facility's licensed nurse, and the administrator. The pharmacist shall document the review by preparing a monthly report of the potential irregularities and recommendations. The administrator shall retain the report in the assisted living center. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to ensure four of four sampled residents (1, 5, 6, and 7) pharmacist drug regimen reviews (DRR) had been received by the facility for the previous twelve months. Findings include:	S 621	Director reviewed and revised policy and procedure as necessary for Pharmacist Services. Pharmacist has agreed to provide the pharmacy monthly forms that are completed each month. Administrator or designee will review medication forms when received for any updates or changes. CKH Administrator or designee will audit monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *The licensed nurse will be involved in the review of the pharmacy consultations. CKH	01/13/2024

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S 621	Continued From page 16 1. Review of residents 1, 5, 6 and 7's care records revealed there were no drug regimen reviews documented. Interview on 11/28/23 at 3:21 p.m. with administrator designee D regarding resident's DRRs revealed: *She was not sure if they had been completed by the pharmacist for the previous twelve months. -She thought maybe he had completed them and had kept them. Interview on 11/29/23 at 11:03 a.m. with director A regarding resident's drug regimen reviews (DRR) revealed she: *Was hired on 9/5/23. *Was not aware a monthly DRR review was required to be completed by the consulting pharmacist. *There was no documentation in the resident's care record that the DRRs had been completed. Review of the provider's undated Pharmacist Services policy revealed: *"3. The pharmacist shall report potential drug therapy irregularities and make recommendations for improving the drug therapy of the resident to the resident's physician, physician assistant, nurse practitioner, the facility's licensed nurse, and the administrator." -"5. The administrator shall retain the report in the assisted living center." A message was left on 11/29/23 at 4:19 p.m. on administrator C's telephone voice mail, no call was returned by the end of the survey.	S 621		
S 642	44:70:07:05 Control And Accountability of Medications	S 642		

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S 642	Continued From page 17 The facility must receive written authorization from the resident's physician, physician assistant, or nurse practitioner before releasing any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on closed care record review and interview, the provider failed to ensure one of one discharged resident's (7) medication amounts that were sent home with him were documented and accounted for. Findings include: 1. Review of resident 7's closed care record revealed: *He was admitted on 7/26/23. *He had discharged to his home on 10/28/23. *The following medications were sent home with him: -Allopurinol 300 mg (milligram) tablets. -Aspirin 81 mg tablets. -Furosemide 20 mg tablets. -Losartan potassium 25 mg tablets. -Metoprolol succinate ER (extended release) 50 mg tablets. -A MiraLax bottle. -Omega-3 fish oil 1000 mg capsules. -Omeprazole 40 mg capsules. -Potassium chloride 10 MEG tablets. -Ranolazine ER 1000 mg tablets. -Senna Plus 8.6-50 mg tablets.	S 642	Director implemented a policy regarding Control and Accountability of Medications. Administrator or designee and anyone else responsible for the transfer or discharge of residents will be re-educated on proper documentation of medications leaving the facility. *CKB Unable to account for the amount of Resident 7's medications when he was discharged on October 28, 2023. Administrator or designee will audit the documentation of medication for all residents that are discharged or transferred weekly for four weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *The re-education for all staff involved in the transfer or discharge of the resident will be documented in the education binder. CKB	01/13/2024

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S 642	Continued From page 18 -Spironolactone 25 mg tablets. -Tamsulosin HCL 0.4 mg capsules. -A saline nasal spray bottle. -Rosuvastatin calcium 40 mg tablets. *There was no documentation of the number of each medication that had been sent home with him. Interview on 11/29/23 at 12:22 p.m. with director A regarding resident 7's medications sent home with him when he was discharged revealed: *She was not aware the documentation of each medication including the amount was required. *She confirmed the number of each medication sent home with him had not been documented. Review of the provider's undated Leave of Absence Medication Policy revealed: *"4. Document: -a. Name & strength of medications along w/number [with the number] of doses sent." Interview on 11/29/23 at 3:27 p.m. with administrator designee D revealed there was no policy specific to medications sent home with a discharged resident.	S 642		
S 680	44:70:07:08 Medication Records And Administration A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication.	S 680	Director has reviewed and revised as necessary the policy and procedure. Director has updated Resident 3 and 4 MAR to the medication labels. Administrator or designee will review and update all other residents MAR to the medication labels. Administrator or designee will continue to monitor all residents MAR to all medications labels with any new physician orders.* CKW Administrator or designee will audit for four weeks and monthly for two months.	01/13/2023

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S 680	Continued From page 19 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 medication labels and the medication administration record (MAR) matched during observed medication administration for two of five sampled residents (3 and 4). Findings included: 1. Observation and interview on 11/29/23 at 11:02 a.m. with medication aide B while administering medications to resident 3 revealed: *The resident's Gabapentin medication pharmacy label on the bubble pack read "Take 2 capsules - 200 mg [milligrams] - by mouth every morning, afternoon, and at bedtime." *Her November 2023 MAR read "Gabapentin 100 mg 1 capsule PO [by mouth] three times daily." -To the right side of the medication administration record after the PO +2 was handwritten. *Medication aide B stated the nurse had written +2 on the MAR when the resident returned from the hospital on 11/7/23 with her Gabapentin dose increased from one 100 mg capsule to two 100 mg capsules. -She agreed the MAR was confusing and it had read like the resident was to receive 1 capsule + 2 for a total of 3 capsules. *She was not sure why it had been written on the MAR that way. Review of resident 3's care record revealed she had an 11/7/23 physician's order for Gabapentin 200 mg three times daily. 2. Observation and interview on 11/29/23 at 11:17 a.m. with medication aide B while administering medications to resident 4 revealed: *The resident's Prednisone medication pharmacy	S 680	Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *All staff responsible for dispensing medication will be re-educated on the policy and procedure. CK	

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label on the bubble pack read "Prednisone 20 mg 1 tablet by mouth in the morning with breakfast."
*His Prednisone medication bubble pack had a noon sticker on it.
*His MAR read "Prednisone 20 mg 1 tablet PO once a day" and it was scheduled on the MAR to be given at noon.

Review of resident 4's care record revealed he had a physician's order for Prednisone 20 mg daily with the time to be given unspecified.

3. Interview on 11/29/23 at 12:25 p.m. with director A regarding the medication labels and the MAR for residents 2 and 3 revealed:
*She was a licensed practical nurse (LPN).
*She made all order changes on the resident's MAR as med aides were not allowed to change orders on the MAR.
*She checked in the medication bubble packs from the Salem pharmacy by:
-Verifying the labels on the medication bubble packs with the MAR, and she placed the stickers for med pass times on the medication bubble packs.
*She confirmed:
-She had written +2 instead of changing 1 capsule to 2 capsules on resident 3's MAR. This was confusing and could have led to a medication error.
-She had placed a noon sticker on resident 4's Prednisone medication bubble pack when the pharmacy label instructed to give it in the morning with breakfast. She had not caught the discrepancy between the medication bubble pack label and the MAR that had his Prednisone scheduled at noon.
*She agreed it was not within the medication aide's role to decide whether to follow resident 4's Prednisone instructions on his medication bubble

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S 680	Continued From page 21 pack to give the medication at breakfast with food or to follow the MAR instructions and give his Prednisone at noon. -The MAR should have matched the pharmacy label and the orders. Review of the provider's undated "Medication Control Policies & Procedures" revealed: *"The purpose of this policy is to ensure the safe administration of medications to the resident by the medication aide." -"Medication records will be checked regularly against Doctor's orders by our Nurse Consultant and by our pharmacist from Salem Drug. Any errors or reactions must be reported immediately to the administrator and noted on the med sheet and in the resident's file and then reported to the RN and/or resident's physician."	S 680		
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.	S 685	Director removed OTC medications from resident 2's room and contacted PCP. Received orders for the OTC medications. Medication Aides are administering all medications to resident 2. Director removed resident 1's eye drops from room. Received orders for OTC eye drops on 12/4/23. Will keep OTC eye drops in med cart for Medication Aide to administer. Director obtained self administration order to administer insulin for resident 2 under the supervision of a medication aide.* CKP Director has educated residents with self administration orders regarding the importance of needing a doctors order for all medications at bedside and when going to the doctor to take a "doctor visit form" along to appointments. Nurse consultant or designee will complete a quarterly check for medications at bedside form for all residents with orders for self administration.	01/13/2024

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S 685	Continued From page 22 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure safe self-administration of medication practices for two of two sampled residents (1 and 2) who had not had: *Physician's orders for all the medications they had stored in their room and had self-administered. *Initial and quarterly self-administration assessments for all medications they had stored and self-administered to indicate they could self-administer those medications safely. Findings include: 1. Observation and interview on 11/28/23 at 1:38 p.m. with resident 1 in her room revealed: *She did not keep any medications in her room, the staff brought her medications to her. *The only medication she self-administered was injecting herself with insulin after the staff had prepared it and brought it to her room. *A bottle of Refresh eye drops was sitting on a table next to a chair in her room. *When asked about the Refresh eye drop bottle, she stated her eye doctor had given her the Refresh eye drops at her eye appointment. -She used the Refresh eye drops when her eyes felt dry. *She had not recorded when she administered the eye drops or informed staff if she had administered them. *Staff had not asked her if or when she had administered the eye drops. Review of resident 1's care record revealed: *She was admitted on 8/31/21. *Her diagnoses included Diabetes.	S 685	Administrator or designee will audit for four weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring. *The OTC medications have been added to the MAR.	

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S 685	Continued From page 23 *Her most recent Brief Interview for Mental Status (BIMS) dated 9/26/23 revealed a score of 10, indicating she had moderate cognitive impairment. *She had the following physician's orders related to self-administering medications: -Dated 8/31/21, the physician's signature was on forms titled "Approval for Resident to Self Medicate " and "Bedside Medication Authorization Form". -Neither form had medications listed on them and they had "See list" written on them. *There was no physician order for the Refresh eye drops. Review of resident 1's November 2023 medication administration record (MAR) revealed: *There were no Refresh eye drops listed. *There was a Fluticasone inhaler listed on her MAR and it read "May keep in her room". Review of resident 1's service plan initiated on 12/16/21 and updated on 6/9/23 revealed: *She gives insulin injections to herself. *Her medications were stored, secured, and administered by staff. -There was no information the resident may self-administer medications. 2. Observation and interview on 11/29/23 at 11:25 a.m. with medication (med) aide B during med pass revealed: *Resident 2 had a bottle of Latanoprost eye drops stored in her personal refrigerator in her room. -Staff checked and recorded the temperature of her personal refrigerator daily and documented it on the MAR. *Stored in her refrigerator next to the Latanoprost eye drops were the following over the counter (OTC) medications:	S 685		

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-A bottle of artificial tears.
-A bottle of lubricating eye drops.
-A single vial of Refresh lubricating eye gel.
-Two bottles of Afrin nasal spray.
*Med aide B stated the OTC medications were not administered by staff and they were not listed on resident 2's MAR.
-She was not sure if resident 2 had been approved for self-administration of medications.

Review of resident 2's care record revealed:
*She had a BIMS score of 6 indicating she had severe cognitive impairment.
*She had a physician's order for Latanoprost eye drops 0.0005% one drop in both eyes at bedtime.
*There were no physician orders for the other OTC medications stored in resident 2's refrigerator in her room.
*None of the OTC medications stored in resident 2's refrigerator in her room were listed on her MAR.
*There was no self-administration of medication assessment or bedside medication authorization form in her care record.

3. Interview on 11/29/23 at 12:25 p.m. with director A regarding residents 1 and 2's self-administration of medications revealed:
*Resident 1 only self-administered her insulin after the med aide had prepared it and had taken it to the resident in her room.
-There were no other medications she self-administered.
*She had been unaware that resident 1 had been to the eye doctor and had Refresh eye drops in her room or that she was self-administering the Refresh eye drops.
*She was sure and confirmed resident 1 did not keep her Fluticasone inhaler in her room.
*She was unaware that resident 2 had a bottle of

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	42874	A. BUILDING: ______ B. WING ______	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING	600 S HILL ST SALEM, SD 57058

(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 685	Continued From page 25	S 685		

artificial tears, a bottle of lubricating eye drops, a single vial of Refresh lubricating eye gel, and two bottles of Afrin nasal spray in her refrigerator in her room.
*Residents and/or their families would bring in medications at times, and they would not always inform staff of the new medications.
*She confirmed:
-Resident 1 had no physician's orders for the Refresh artificial tears, no "Doctor's Visit Form" from her eye doctor appointment, no quarterly self-administration of medication assessments, and no completed nurse consultant quarterly checks for medications at the bedside.
-Resident 2 had no physician orders for the artificial tears, lubricating eye drops, Refresh lubricating gel, or Afrin nasal spray, no initial or quarterly self-administration of medication assessments, and no completed nurse consultant quarterly checks for medications at the bedside.
-She was not aware of all the requirements for self-administration of medications for residents living in assisted living centers.
-There should have been physician orders for all the resident's medications, and for the self-administration of those medications.
-She was not aware of the requirement for quarterly assessments for self-administration of medications.
-The provider's self-administration of medication policy had not addressed the specific requirements for assisted living centers.

Review of the provider's undated "Policy for Self-Medication Administration" revealed:
*"1) A written doctor's order stating the resident may safely self-administer medications at the bedside will be obtained.
*2) A "Policy for Self-Medication Administration" form will be filled out and signed by the resident

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S 685	Continued From page 26 and/or family. *3) If the healthcare provider feels that the resident is appropriate to safely self-administer medications at the bedside, that information will be included on any prescription issued that will be used by the resident at the bedside. *4) The resident and/or a family member must make the facility aware of each doctor appointment prior to that appointment. *5) Resident must take a "Doctor Visit Form" to each doctor appointment including a copy of the facility's medication administration record where bedside medications are noted in the record. *6) By returning the Doctor Visit Form, the facility, the family and the resident will be made aware of all medication changes, including over the counter medications." "*8) Nurse consultant will complete a "Quarterly Check for Medications at Bedside" form." Review of the provider's undated "Medication Control Policies & Procedures" policy revealed: *"Residents who have medications in their room must have a written Doctor's order that this resident is capable of having bedside meds. The Nurse Consultant will regularly check that this resident is following Doctor's orders concerning their medication." *The policies had not included information about: -Completing initial and quarterly assessments for continued appropriateness of the resident's ability to self-administer medications.	S 685		
S 800	44:70:09:04 Notification When Resident's Condition Change A facility shall immediately inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and, if known,	S 800		

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S 800	Continued From page 27 notify the resident's legal representative or interested family member when any of the following occurs: (1) An accident involving the resident that results in injury or has the potential for requiring intervention by a physician, physician assistant, or nurse practitioner; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the facility 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 a resident's physician was notified and aware of potential safety concerns for one of one sampled residents (1) who had driven herself to church on the wrong day of the week and had not been dressed appropriately while out in public. Findings included: 1. Observation and interview on 11/28/23 at 1:38 p.m. with resident (1) in her room revealed: *She was lying on her couch. *She was dressed and her hair looked to have not been combed. *She had lived at the facility for approximately four years. *She had two sons, one was her power of attorney, and they were involved in her care. *Her physician was contacted by either her son or the nurse at the facility. *She had her car and still drove. Review of resident 1's care record revealed: *She was admitted on 8/31/21. *She had a 12/20/22 Brief Interview for Mental	S 800	Director reviewed and updated Notification when residents condition change policy. Administrator or designee will be re-educated on proper notification to physican for change of condition. Administrator or designee will notify residents physician, physician assistant or nurse practitioner and if known, the residents legal representative or family member for any changes in condition with the resident. Director notified primary physician of resident 1's change of condition, no new orders obtained. Administrator or designee will audit for four weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring.	01/13/2024

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Status (BIMS) score that had been documented as 14 indicating she was cognitively intact.
*Her most recent BIMS score dated 9/26/23 was documented as 10 indicating she had moderate cognitive impairment.
*Weekly review documentation dated 11/2/23, a Thursday, revealed:
-She was alert and oriented with occasional confusion.
-"Today, resident drove to her church thinking it was Sunday. She showed up to the church without putting any pants on. Will continue to monitor for changes."
-There had been no follow up notes indicating monitoring of the resident for this.
*Her service plan initiated on 12/16/21 and updated on 6/9/23 regarding transportation revealed:
-She will have her transportation needs met.
-The person providing transportation was family or administration.
-The service was provided by contacting family as needed.
-There was no documentation of her having a car at the facility or that she drove her car.
-There was no documentation of her having been dressed inappropriately in public.
*Her Assisted Living Resident Evaluation Tool was initiated on 8/31/21 and completed yearly with the most recent date of 9/5/23. *That tool documented she was:
-Independent and required no assistance with dressing.
-Alert and oriented to person/place/time and made independent decisions regarding tasks of daily living.
-Independent and made decisions consistently and reasonably.
-Without displays of socially inappropriate behavior.

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-Not at risk for elopement.

Interview on 11/29/23 at 3:25 p.m. with director A regarding resident 1 revealed:
*From time to time this resident got confused.
*She had called the resident's sons and notified them of the incident when she drove to church without pants on.
-The sons had stated she liked sitting in her car and they were not going to take her car away until she had an accident or had been ticketed.
*She confirmed the resident was not safe to have been driving.
*She had not notified the resident's physician of that incident because it was not a new issue or a change in condition for the resident.
*The resident had these same behaviors since she had lived at the facility.
-She had come out of her room in her underwear and no shirt once before.
-She had driven once before without a shirt on.
-The resident had been seen recently by her physician but could not confirm he was aware of her driving without pants on as the family took her to appointments.
*She agreed this was a safety concern when the resident was not aware of the day of the week or was inappropriately dressed and was driving.

Review of the provider's June 2021 Notification When Resident's Condition Changes policy revealed:
*"Policy: Leisure Living will inform the resident, consult with the resident's physician, physician assistant, or nurse practitioner, and if known, notify the resident's legal representative or interested family member when any of the following occurs:
-An accident involving the resident that results in

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S 800	Continued From page 30 injury or has the potential for requiring intervention by a physician, physician assistant, or nurse practitioner. -A significant change in the resident's physical, mental, or psychosocial status. -A need to alter treatment significantly."	S 800		

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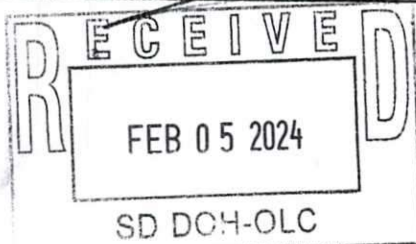
{S 000}	Compliance Statement An onsite revisit survey was conducted on 1/23/24 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 11/29/23. Leisure Living was found not in compliance with the following requirement: S-0169.	{S 000}		
{S 169}	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, interview, record review, and policy review the provider failed to maintain an electrically activated audible alarm on three of four exit doors. (main entrance, south wing exit, and north wing exit). Findings include: 1. Observation on 1/23/24 at 8:45 a.m. when entering the facility revealed the unattended main entrance door to the building was equipped with a door alarm but had not sounded when the door was opened. 2. Random observations on 1/23/24 between 12:45 p.m. and 1:00 p.m. revealed: *Residents had opened the south wing back door of the facility.	{S 169}	Director educated all staff on door alarms and reviewed and updated Occupant Protection policy. Door Alarms will continue to be on at all times while facility has Cognitive Impairment residents. Director or Designee will continue to monitor the BIMS of all residents. Director or designee will monitor door alarms daily for 7 days and then one time a week for three weeks and then monthly for 12 months. Director or designee will present findings from these audits at the monthly QA committee for review.	03/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/5/24



South Dakota Department of Health

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*The interior screen door with a window was closed but the exterior door was left open.
*Three unidentified residents were outside at the smoking area just outside of that opened, unattended, and unalarmed exit door.
*They were alone, with their coats on, standing or sitting on their wheeled walker seats smoking.

Interview and testing on 1/23/24 at 1:15 p.m. with administrator designee A and director B at 1:15 p.m. revealed:
*The building's door alarm system panel was outside of the director's office and was not functioning correctly when tested for each of the doors but the switch had been placed into the off position.
*The director stated the facility was licensed for residents with cognitive impairments but they did not have the alarms on during the daytime hours.
*The door alarms were turned on and tested at night.
*The director stated the alarming going off each time the doors were opened would have agitated residents with cognitive impairment.
*They confirmed the exit doors were not in compliance with the rule for residents with cognitive impairment which was to be locked, alarmed, or attended.
*They confirmed their 12/2023 Occupant Protection policy was not in compliance with the rule for residents with cognitive impairment which was exit doors were to be locked, alarmed, or attended.

Review of the door alarm audits conducted as part of the provider's plan of correction from the 11/29/23 survey for not having the door alarms on revealed:
*The facility's door alarms were tested nightly on 12/14/23 through 12/20/23, then once weekly on

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	42874	A. BUILDING ______ B. WING ______	R 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 169}	Continued From page 2	{S 169}		

12/27/23, and again on 1/3/24 at 2200 [10 p.m.].
*Those audits revealed the alarms were on and working at the time of the audits.
*There was no documentation regarding the door alarms during the daytime.

Review of the providers 12/2023 Occupant Protection policy revealed:
*"Policy
-It is Leisure Living Salem Assisted Living policy to provide its residents with a safe environment in accordance with 44:70:02:17.
*Procedure
-Leisure Living Salem is constructed, arranged, equipped, maintained, and operated to avoid injury or danger to our residents. Leisure Living Salem provides the following to ensure safety:"
--"7. Main Entrance, South wing exit, North wing exit, and patio doors to the building will be locked between the hours of 2000 [8 p.m.] and 0600 [6 a.m.]. The door alarms will be put on at 2000 & remain on until 0600. All doors may be unlocked from 0600-2000. Residents may come and go as they please. There will be a sign out sheet on the table by the entry way that residents can sign in/out."

The deficiency had the potential to affect all residents of the facility with cognitive impairment.

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	42874	A. BUILDING: ____ B. WING ____	R 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING	**600 S HILL ST SALEM, SD 57058**

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{S 000}	Compliance Statement A second onsite revisit survey was conducted on 4/4/24 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 11/29/23 and 1/23/24. All deficiencies have been corrected, and no new noncompliance was found. Leisure Living was found in compliance.	{S 000}		

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