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
	10745	A. BUILDING: _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE INN ON WESTPORT	4000 S. WESTPORT AVENUE SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/7/23 through 8/9/23. The Inn on Westport was found not in compliance with the following requirements: S200, S201, S405, and S642.	S 000		
S 200	44:70:03:01 General fire safety Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition. An automatic sprinkler system is not required in existing facility unless significant renovations or remodeling occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow tests not done for 2021, 2022, and 2023). Findings include: 1. Record review on 8/8/23 at 12:45 p.m. revealed there was no documentation of required quarterly flow tests for the past three years (2020, 2021, and 2022). No quarterly flow tests had been performed in 2023. Records indicated annual sprinkler inspections had been performed 9/28/20, 9/14/21, and 10/4/22 and a 5-year internal obstruction inspection of the sprinkler system had been done in 9/18.	S 200	A quarterly flow test was performed on 8/23/23. Annual sprinkler inspections will continue as scheduled. Quarterly inspections have been added to Maintenance Connection, the facility maintenance management system under preventative maintenance. The Maintenance Director will be reminded through this system quarterly to complete the inspections. Documentation of compliance will be completed in Maintenance Connection. ED will monitor quarterly for 12 months to ensure compliance. ED and Maintenance Director will report audit results to QA committee at the monthly meeting.	8/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kyrsten Fokken

TITLE: Executive Director

(X6) DATE: 9/6/23

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S 200	Continued From page 1 Automatic sprinkler and standpipe systems must be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. Interview with administrator at the time of the record review confirmed that condition. She stated the provider had several new maintenance employees in 2023. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	S 200		
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 fire alarm system must be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on record review and interview, the facility failed to test and document the fire alarm system as required (listing of devices and smoke detector sensitivity). Findings include:	S 201	Testing of fire alarm system which will include an itemized list with the device type, address, location, and sensitivity results of the smoke detectors is scheduled to be completed by outside contractor was completed on8/29/23. Fire inspection including the listing of devices and smoke detector sensitivity is now scheduled annually with a reminder in Maintenance Connection for facility follow-up of vendor. Maintenance Director will report completion to QA committee which meets on a monthly basis.	8/29/23

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S 201	Continued From page 2 Record review of the fire alarm system dated 9/15/22 revealed device test results (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following information, device type, address, location, and test result as required. There was no documentation of smoke detector sensitivity testing results. A fire alarm system must be tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing must be readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. Interview with the administrator at the exit interview confirmed those findings. The deficiency affected two of numerous fire alarm test requirements affecting the building. B. Based on observation and interview, the provider failed to maintain one randomly observed hazardous areas (second floor communications room) as required. Findings include: 1. Observation on 8/8/23 at 2:10 p.m. revealed the second floor communications room was over 100 square feet in area and held copious amounts of combustible items (boxes and paper goods) as well as the communications cabling. The corridor door was equipped with an	S 201	B. The ball and socket magnetic device was removed from the referenced fire door 8/23/23 to prevent misuse. All other fire doors within the community will be evaluated by the maintenance director and maintenance assistant by 8/31/23 to ensure compliance.	8/23/23

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S 201	Continued From page 3 automatic closer, but the door was held open with a ball and socket magnet device at the base of the door. The magnet was not a device that could be tied in to the fire alarm system to automatically release upon activation of the fire alarm system. The door remained open throughout the fire drill held at 2:05 p.m. on the second floor. Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Interview with the administrator at 2:20 p.m. confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	S 201		
S 405	44:70:05:02 Resident care plans, service plans, and prog The nursing service of a facility shall provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans or service plans for each resident. The care plan or service plan shall address personal care and the medical, physical, mental, and emotional needs of the	S 405	Resident 1's service plan has been updated to include documentation of the wound and required cares on 8/10/23. Resident 3's service plan was updated to include hospice status 8/11/23. Resident 5's service plan was updated to indicate he is a smoker on 8/11/23. DON or designee will audit service plans x 4 monthly to ensure compliance. The service plan policy was reviewed to ensure it is followed appropriately. All deficient service plans have been updated to ensure compliance. Audits of all service plans will be completed by the DON or designee with results reported to the QA committee on a monthly basis until adequate compliance is determined by QIC. DON provided 1 to 1 training specific to service plans with 3 Resident Care Coordinators on 8/22/23.	8/22/23

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S 405	Continued From page 4 resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to develop and implement a comprehensive, individual service plan/care plan to meet the care needs of three of nine sampled residents (1, 3, and 5). Findings include: 1. Review of resident 1's care record revealed: *He was admitted on 12/1/22. *He developed a wound to his lower left leg that was identified on 7/25/23. *Observation and interview with resident 1 on 8/8/23 at 10:30 a.m. confirmed the presence of the wound. *The wound required ointment and a bandage. *His wound was being measured and assessed. *Review of his undated care plan and his 8/9/23 service plan revealed there was no documentation in either plan that the resident had wound. 2. Review of resident 3's care record revealed she was admitted on 3/5/22. Interview on 8/9/23 at 2:00 p.m. with licensed practical nurse (LPN) N revealed: *Resident 3 was placed on hospice in December 2022, and remained in hospice. *Review of resident 3's undated care plan and her 4/19/22 service plan revealed there was no documentation in either plan to indicate she had been placed on hospice. 3. Review of resident 5's care record revealed: *He was admitted on 3/3/23. *He smoked tobacco. *Interview on 8/9/23 at 2:00 p.m. with LPN N	S 405		

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S 405	Continued From page 5 confirmed a smoking assessment had been completed when the facility found out he smoked, and will continue to be assessed quarterly for safe smoking. *Review of resident 5's undated care plan and his 8/9/23 service plan revealed there was no documentation to indicate he was a smoker. 4. Interview on 8/9/23 at 4:30 p.m. with administrator A and director of nursing B revealed: *The above care plans/service plans should have included the sufficient information to care for the residents. *The provider used the service plans for monitoring the amount of units of time the provider provided. *The service plan policy was used as a care plan policy. 5. Review of the revised 8/1/23 Service Plans policy revealed the provider: *Created individualized service plans to meet the residents' needs. *Was to have included resident's preferences to support the principles of dignity, privacy, choices, individuality, and preferences. *Was to have reviewed and updated the service plan whenever a change was noted, and service changes when necessary.	S 405		
S 642	44:70:07:05 Control and accountability of medications Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication	S 642	Requested disposition documentation was located on 8/13/23 and faxed to DOH surveyor on 8/14/23. The physician's order to transfer resident 10's medication was located and is in the medical record. DON provided 1 to 1 training to Resident Care Coordinators on 8/22/23 regarding documentation of disposition of medications and obtaining a physician's order to send medications with a resident when discharged. Medication disposition policy was reviewed and does include required written physician authorization instructions. DON will audit all discharged residents to alternative facilities for a 12 month period. Audit results will be shared at monthly QA meeting by DON.	8/22/23

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S 642	Continued From page 6 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, interview, and policy review the provider failed to maintain written authorization by the resident's physician and documentation indicating the medications names, quantities, and strength for the disposition of those medications for one of two sampled discharged residents (10). Findings include: 1. Review of resident 10's closed electronic care record revealed: *On 5/18/22 the resident was discharged to a long-term care facility with his belongings and his medication at the request of the admitting facility who would have been caring for him. *No physician's order to send the medications with the resident had been located. *No disposition form with a list of the medications sent with the resident had been located. A request for the documentation for the disposition of medications for resident 10 to director of nursing (DON) B and administrator A revealed: *The were unable to locate the disposition of medications form for resident 10. *They agreed the resident should have had a disposition of medications form completed with a list of his medications that were sent with him at the time of his discharge in his care record.	S 642		

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S 642	Continued From page 7 A request from administrator A and DON B for the provider's disposition of medications policy. A 8/1/23 Medication Destruction policy had been provided instead. That policy indicated: *The policy was to establish a procedure for the destruction and disposition of unused medications. -It had no information regarding the process of the disposition of medications when a resident had been discharged to another facility with their medications.	S 642		

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{S 000}	Compliance Statement A 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 9/14/23 and on 9/19/23 for deficiencies cited on 8/9/23. All deficiencies have been corrected, and no new noncompliance was found. The Inn On Westport is in compliance with all regulations surveyed.	{S 000}		

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