DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST LAKE ANDES, SD 57356

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 41088 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/6/22 through 3/8/22. Lake Andes Senior Living was found not in compliance with the following requirement: F645.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645	1. In continuing compliance with F 645 PASRR Screening for MD & ID Lake Andes Senior Living corrected the deficiency by correcting resident 9's PASRR on 3/7/22 by SSD. All resident PASRR's were reviewed to ensure accurateness by Social Service Designee on 3/8/22. 2. To correct the deficiency and to ensure the problem does not recur Social Service Designee was educated on PASRR requirements by Contracted Licensed Social Worker on 3/16/2022. The SD PASRR manual was reviewed by the ED and provided to the SSD. The Social Services Designee and/or designee will audit all resident PASRRs weekly for 3 months to ensure accurateness. Updated 4/7/22 TB. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Social Services Designee and/or designee will report identified concerns through the community's QA Process for 3 months. 4. The Social Service Designee is responsible for this area of compliance.	4/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Tammy Boettcher, LNHA

TITLE

(X6) DATE
4/1/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	435097	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST LAKE ANDES, SD 57356

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F 645	Continued From page 1 (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by:	F 645		

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F 645	Continued From page 2 Surveyor: 45683 Based on record review, interview, document review, and reference manual review, the provider failed to ensure one of twelve sampled residents (9) had a level two pre-admission screening and resident review (PASRR) completed. Findings include: 1. Review of resident 9's medical record revealed: *She: -Was admitted on 10/11/21. -Had a diagnosis of schizophrenia, unspecified. -Had a level one PASRR completed on 10/6/21. -Had received a level two PASRR exception for a nursing home or swing bed stay following hospitalization which would be for less than 100 days. *Social services designee (DSS) G had not followed up on a level two PASRR once the exception expired on 1/16/22. Review of resident 9's 10/6/21 level one PASRR report revealed: *Nurse consultant H with the department of human services recommended per 3/7/22 email: -"Yes, if you still have [resident 9], you are way overdue. -You must always look at what the PASRR says a 100d rehab require you to follow up on and the same with a 30 day Respite stay one. -So for [resident 9], yo[sic] out the level 2 form and send me all the info it asks for so I can submit for a level 2 PASRR. -Thank you." Interview on 3/7/22 at 1:34 p.m. with DSS G regarding the level two PASRR for resident 9 revealed:	F 645		

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F 645	Continued From page 3 *Resident 9 had required a level two PASRR since she had stayed past her 100 days. *She had overlooked the date the level two PASRR had been due. Interview on 3/8/22 at 1:20 p.m. with executive director A regarding the facility's policy for PASRR completion revealed: *They used the South Dakota PASRR Reference Manual. *They had started a performance improvement plan to focus on PASRR completion. *She expected the PASRR to have been completed in an appropriate time frame. Review of the January 2015 South Dakota PASRR Reference Manual revealed; *A nursing home resident could get an exception for a level two PASRR for rehabilitation purposes up to 100 days following a hospital stay. *If there was a change in the resident's discharge plan the facility needed to notify the department of social services to review. *The facility needed to contact the department of social services before the exception ended for review and re-approval.	F 645		

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E 000	Initial Comments Surveyor: 41088 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 3/6/22 through 3/8/22. Lake Andes Senior Living was found in compliance.	E 000		

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

Jan Bottum, LNHA | 4-1-2022

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	435097	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	**740 EAST LAKE ST** **LAKE ANDES, SD 57356**

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/8/22. Lake Andes Senior Living was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K271, K345, K353 and K712 in conjunction with the provider's commitment to the continued compliance with the fire safety standards.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation, testing, and interview, the provider failed to provide a clear egress discharge path to the public way. Four of seven exit discharge paths (east wing, rear dining area, and two emergency staff basement exits) were not cleared of snow. Findings include: 1. Observation on 3/8/22 at 8:45 a.m. revealed the east wing exit discharge was not cleared of	K 271	In continuing compliance with K271 Discharge from Exits Lake Andes Senior Living corrected the deficiency by clearing snow from the four exit discharge paths to the public way on 03/08/2022. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Supervisor was educated on 03/08/2022 on regulation NFPA101 by Executive Director. T he Executive Director and/or designee will audit that all exits are free of snow or debris following any kind of snow fall and through weekly safety rounds. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process. 4. The Executive Director is responsible for this area of compliance.	3/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Tammy Boettcher, LNHA

TITLE

(X6) DATE
4/1/2022

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K 271	Continued From page 1 snow to the public way. Measuring revealed approximately two inches of snow was on the discharge path. Interview with maintenance at the time of the observation confirmed that condition. He stated he thought clearing the door was adequate. 2. Observation on 3/8/22 at 10:10 a.m. revealed the rear dining exit discharge was not cleared of snow to the public way. Measuring revealed approximately two inches of snow was on the discharge path. Interview with maintenance at the time of the observation confirmed that condition. He stated he thought clearing the door and patio area was adequate. 3. Observation on 3/8/22 at 10:20 a.m. revealed the exit discharge at the two emergency staff exits from the basement (boiler room and storage area) were not cleared of snow to the public way. Measuring revealed approximately two inches of snow was on the egress path. Interview with maintenance at the time of the observation confirmed that condition. He stated he did not know staff exits needed to be cleared. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 271		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is 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 are readily	K 345	See next page	

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K 345	Continued From page 2 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review and interview, the provider failed to do the annual test for the fire alarm system as required for calendar year 2020 or 2021. Findings include: 1. Record review on 3/8/22 at 10:40 a.m. revealed there was no documentation an annual fire alarm inspection and testing had been performed for calendar year 2020 or 2021. No records were available for prior years, but our previous survey documented testing. Interview with maintenance at the time of record review revealed an individual from ADS, a fire alarm company, had come on an unspecified date and there were two COVID cases in the building. The individual said he was not allowed to enter, but no further testing was attempted. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants.	K 345	1. In continuing compliance with K345 Fire Alarm System- Testing and Maintenance Lake Andes Senior Living corrected the deficiency by having ABC Automatic Building Controls perform annual fire alarm inspection and testing on 03/16/2022. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Director was educated on 03/08/2022 on NFPA 70& 72 requirements of annual fire alarm inspection by Executive Director. Maintenance Director will maintain fire alarm system records and ensure that annual fire alarm inspection be completed annually through facility TELS system. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified concerns through the community's QA Process. 4. The Maintenance Director is responsible for this area of compliance.	3/16/22
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are 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	K 353	See next page	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	**740 EAST LAKE ST** **LAKE ANDES, SD 57356**

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K 353	Continued From page 3 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in calendar year 2021 or 2022). Findings include: 1. Record review on 3/8/22 at 10:30 a.m. revealed the required quarterly flow tests had not been performed in the past year. No quarterly testing was found documented in the maintenance records, though annual testing was performed in calendar years 2020 and 2021. Interview with maintenance at the time of the record review confirmed that condition. 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.	K 353	1. In continuing compliance with K353, Sprinkler System – Maintenance and Testing Lake Andes Senior Living corrected the deficiency by completing annual sprinkler inspection with Builder Sprinkler on 03/29/2022. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Director was educated on 03/08/2022 on NFPA 25 requirement of annual sprinkler inspections by Executive Director. The Executive Director and/or designee will audit TELS to ensure annual sprinkler inspection and quarterly flow tests are completed. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process. 4. The Executive Director is responsible for this area of compliance.	3/29/22
K 712 SS=E	Fire Drills	K 712		

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K 712	Continued From page 4 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 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) for two of four yearly quarters from March 2021 through March 2022. Findings include: 1. Record review on 3/8/22 at 10:55 a.m. revealed there was no documentation of fire drills for two of three months in quarter one (April and May missing) in 2021. There also was no documentation of fire drills for two of three months in quarter four (December 2021 and February 2022 missing). Interview with the maintenance supervisor at the time of the record review confirmed those findings. He stated he was a new employee since October 2021. He added he was asked to make the remodels he has been doing a priority. The deficiency had the potential to affect 100% of	K 712	. In continuing compliance with K712, Fire Drills Lake Andes Senior Living corrected the deficiency by conducting a fire drill 03/30/2022. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Director was educated on 03/08/2022 on NFPA 101 monthly fire alarm testing by Executive Director. The Executive Director and/or designee will audit TELS monthly to ensure fire drills have been conducted. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process. 4. The Executive Director is responsible for this area of compliance.	3/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 712	Continued From page 5 the occupants of the building.	K 712		

South Dakota Department of Health

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	10638	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 E LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

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S 000	Compliance/Noncompliance Statement Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/6/22 through 3/8/22. Lake Andes Senior Living was found not in compliance with the following requirement: S169 and S206.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to ensure an electrically audible alarm on all unattended exit doors were provided on one of five exit doors to the exterior (door at west wing exit). Findings include: 1. Observation and testing on 3/8/22 at 10:00	S 169	1. In continuing compliance with S 169 Occupant Protection Lake Andes Senior Living corrected the deficiency by scheduling Stanley Healthcare to fix the west wing door per regulation on 3/30/2022. 2. To correct the deficiency and to ensure the problem does not recur maintenance director employed as of 03/08/2022 was educated on 03/08/2022 on Regulation 44:73:02:18(5-7) by Executive Director and New Maintenance Director as of 03/22/2022 was educated on 03/22/2022 by Executive Director. The Maintenance Director and/or designee w ill test operation of doors and locks weekly though f acility TELS program. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Maintenance Director and/or designee will report identified c oncerns through the community's QA Process. 4. The Maintenance Director is responsible for this area of compliance.	4/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Boettcher, LNHA | TITLE | (X6) DATE: 4/1/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10638	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 E LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 169	Continued From page 1 a.m. while touring the facility found an unprotected door. The door release warning on the west wing exit door was present, but when the door was tested no alarm sounded. Maintenance commented it was broken, then demonstrated when alarm was switched on, it sounded at all times. All exit doors to the exterior must be locked, attended, or always alarmed. Interview on 3/8/22at 11:45 a.m. with maintenance and the administrator confirmed the above condition. The administrator commented the alarm company was short-staffed and had been unable to repair it. The administrator acknowledged two residents frequently wander and are at risk.	S 169		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and	S 206	1. In continuing compliance with S 206 Personnel Training. Lake Andes Senior Living corrected the deficiency by ensuring new hire training was completed for employees C, D, E, and F on 4/8/2022. Training was completed individually through Relias online learning. This was verified by the ED. 2. To correct the deficiency and to ensure the problem does not recur all staff will be educated on 03/30/2022 on importance of completing new hire and annual training via Relias by Executive Director. The ED reviewed the SD training requirements. The Executive Director and/or designee will audit all employees monthly for 3 months to ensure all mandatory trainings have been completed. 3. As part of Lake Andes Senior Living ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the facilities QA Process for 3 months. Updated 4/7/22 TB 4. The Executive Director is responsible for this area of compliance.	

South Dakota Department of Health

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S 206	Continued From page 2 hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29354 Based on record review and interview, the provider failed to ensure: *Three of five recently hired sampled employees (C, D, and E) had received orientation training for 8 of 12 mandated topics (fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, care of residents with unique needs, dining assistance, nutritional risks, hydration, and facility identified needs.) *One of five recently hired sampled employees (F) had received orientation training for 7 of 12 mandated topics (fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, care of residents with unique needs, and facility identified needs.) Findings include: 1. Review of employees C, D, and E's personnel files and orientation records revealed: *The employees had been hired on the following	S 206		4/12/22

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S 206	Continued From page 3 dates: -Certified nursing assistant (CNA) C on 1/31/22. -CNA D on 12/18/21. -Licensed practical nurse E on 11/30/21. *There had been no documentation of orientation training on fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, care of residents with unique needs, dining assistance, nutritional risks, hydration, and facility identified needs. 2. Review of employee F's personnel file and orientation record revealed: *Cooks assistant F had been hired on 1/6/21. *There had been no documentation of orientation training on fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, care of residents with unique needs, and facility identified needs. Interview on 3/8/22 at 1:25 p.m. with executive director A regarding new employee orientation revealed: *She confirmed employees C, D, E, and F had not completed the above required mandated topics. *The provider had no policy on the mandated training topics for all employees. *She expected to have had the state regulation for the orientation training program for all employees to have been completed.	S 206		
S 000	Compliance/Noncompliance Statement Surveyor: 41088	S 000		

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S 000	Continued From page 4 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/6/22 through 3/8/22. Lake Andes Senior Living was found in compliance.	S 000		