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
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 11/4/25 through 11/5/25. Leisure Living Hartford was found not in compliance with the following requirements: S173, S201, S285, S295, S296, S305, S506 and S685.	S 000		
S 173	44:70:02:17(8-9) Occupant Protection The facility shall: (8) Ensure that any clothes dryer must have a galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in accordance with UL 2158A; and (9) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. A resident may store in the resident's room a maximum of three E-cylinders or seventy-two cubic feet, or 2.040 cubic meters of oxygen on an as-needed basis, in addition to oxygen in use by the resident. If a facility admits or retains a resident not capable of self-preservation, the facility must meet NFPA 101 Life Safety Code, 2012 edition, health care occupancy standards in chapter 18 or 19, or equip the facility with complete automatic sprinkler protection. This Administrative Rule of South Dakota is not met as evidenced by:	S 173	Administrator immediately found storage racks for the unsecured oxygen tanks. Administrator called family of residents to have oxygen supply company pick up any empty tanks. Policy was reviewed by the administrator and then provided oxygen tank education to all staff as per policy. Weekly audits of oxygen storage will be completed for one month then monthly for three months by the administrator or designee. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brianna Morris
TITLE: Adminstrator
(X6) DATE: 11/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 173	Continued From page 1 Based on observation and interview the provider failed to: *Store three C sized oxygen cylinders (compressed gas cylinder approximately 4.5 inches wide and fourteen inches tall) in a secure storage rack in the storeroom by resident room 109. *Store five C sized oxygen cylinders in a secure storage rack in resident room 109. Findings include: 1. Observation and interview on 11/4/25 at 12:30 p.m. in the storage room by resident room 109 with administrator A revealed: *There were multiple oxygen storage racks in the storeroom for different sized oxygen tanks. *All the storage racks were full of cylinders. *There were three full C sized cylinders standing on the floor along the north wall of the storage room. Those cylinders were not stored in a secure rack. *Administrator A was temporarily in charge of this building as the normal administrator was out on extended leave. *She did not know why there were so many oxygen cylinders in the storeroom by resident room 109. *She agreed that all cylinders should have been in a secure storage rack. 2. Observation and interview on 11/4/25 at 12:30 p.m. in resident room 109 with administrator A revealed: *There were two storage racks for C sized cylinders. *Both storage racks were filled with C sized cylinders. *There were five full C sized cylinders standing on the floor next to the full storage racks. Those five	S 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 173	Continued From page 2 cylinders were not stored in a secure rack. *She agreed that all cylinders should have been in a secure storage rack. *She would have to look into why there were more cylinders being delivered than what they had storage for.	S 173		
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 observation, testing, and interview the provider failed to maintain single action latching hardware for three of three exit doors (north door, southeast door, southwest door). Findings include: 1. Observation and testing on 11/4/25 at 11:45 a.m. of the door latching hardware for the southwest exit door revealed: *The lever handle to the door latch would turn about half the distance or forty-five degrees but would not unlatch the door. *In the center of the lever handle was a second knob. That knob would deactivate or activate the locking mechanism depending on its position.	S 201	Administrator has placed an order on new door latching hardware for all three exit doors (north door, southeast door, southwest door. Once installed, administrator will evaluate latching hardware is a one step process to exit the building. All staff have been educated on fire safety requirements and the procedures to report malfunctioning or altered door hardware immediately. Once installed, the administrator or designee will audit one step latching mechanism works properly weekly x4 weeks and monthly x3. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 201	Continued From page 3 *When the knob unlocked the door the lever handle could turn ninety degrees and open the door. *The exit door could not be opened in a single action if it was locked. *It would require two steps to open the door from the locked position. First step would turn the knob unlocking the door latch. Second step would use the lever handle to open the door. 2. Observation and testing on 11/4/25 at 12:15 p.m. of the southeast exit door revealed: *A 8.5 X 11 inch sheet of paper on the window of the door stating in large print "This door is to remain locked." *The door was locked and could not be opened without turning the unlock knob first and then turning the lever handle to open the door. 3. Observation and testing on 11/4/25 at 12:30 p.m. of the front exit door revealed it was also equipped with the same type of door handle. 4. Interview with administrator A on 11/4/25 revealed: *She was not aware the door handles for the three exit doors required two steps to exit. *She was not aware that those doors should have opened with a one-step process or single action.	S 201		
S 285	44:70:04:03 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Personnel on duty must be awake at all times, except as provided in § 44:70:03:02.01. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and	S 285	In accordance to Leisure Living's Personnel policy, the administrator reviewed all employee files to ensure appropriate documents were included in personnel files and that includes background checks. A checklist will be implemented with all new hires to ensure that all required documentation is obtained. The administrator or designee have completed audits on all employees and will complete audit with each new hire for six months.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 285	Continued From page 4 procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or personnel on contract. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review. The provider failed to implement a pre-employment screening process to ensure they had not knowingly hired any person with an abuse conviction for one of five employees (E). Findings include: 1. Review of personnel files revealed: *Employee E's hire date was 5/14/25. -There was no documentation to support a background check was completed for that employee. 2. Interview on 11/5/25 at 1:00 p.m. with administrator A revealed: *She was filling in as administrator while the current administrator was out on leave. *She was familiar with employee files and expected them to be complete. She thought some of the information would be in her office at another facility but was not able to provide that information. 3. Review of the provider's Personnel policy dated 8/27/24 revealed: *"The facility's Administrator will conduct the background investigation on all employees using Background Screeners of America and confirm that the person has a clean record before they will	S 285	Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 285	Continued From page 5 be allowed to start work. The facility will never employ any person known to have a conviction for abusing another person or a conviction for any felony offenses. The facility Administrator will discuss any and all other convictions found on a background check on a case by case basis to determine if the applicant is safe to work with residents. If a current employee commits a crime of violence or abuse, their employment will be terminated immediately. Required for all employees to provide a social security number and a government issued photo ID."	S 285		
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review the provider failed to ensure the required annual training was completed for four of four employees (B, C, D and F). Findings include: 1. Review of personnel file revealed: *Medication Aide (MA) B had been hired 8/26/20. -There was no documentation to support that she had completed annual training on diabetes. *Registered nurse (RN) C had been hired on 7/15/21. -There was no documentation to support she had	S 295	Employees B, C, D, and F have been educated with the annual required training. Employee B, C, D, E have been educated on the training of diabetes. Required annual training will be completed by all employees by the administrator or designee. The annual training will include but is not limited to: Fire Prevention and Response Emergency Procedures and Preparedness: Infection Control and Prevention Abuse, Neglect, and Misappropriation Accident Prevention and Safety Procedures Resident Rights Confidentiality of Resident Information Mandatory Reporting Nutrition and Hydration Needs Care for Unique Needs Restraint Use Diabetes New employees will receive mandatory education upon hire and it will be completed within 30 days of hire. Audits will be completed by administrator or designee with each new hire for six months. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 295	Continued From page 6 completed annual training in 2024 and 2025, as of 11/5/25, for fire prevention and response, emergency preparedness, infection control and prevention, accident prevention and safety procedures, confidentiality, abuse, neglect, and misappropriation of resident property and funds, and education based on the resident care needs. *MA D had been hired on 7/29/10. -There was no documentation to support that she had completed annual training in 2024 and 2025, as of 11/5/25, for fire prevention and response, emergency preparedness, infection control and prevention, accident prevention and safety procedures, confidentiality, abuse, neglect, and misappropriation of resident property and funds and education based on the resident care needs. *Housekeeper (HSKPR) F had been hired on 12/14/21. -There was no documentation to support that she had completed annual training in 2024 and 2025, as of 11/5/25, for fire prevention and response, emergency preparedness, infection control and prevention, accident prevention and safety procedures, confidentiality, abuse, neglect, and misappropriation of resident property and funds, education based on the resident care needs. 2. Interview on 11/5/25 at 1:00 p.m. with administrator A revealed: *She was not surprised that the employee training had missing files and stated, she did not know how to get staff to come in get their required training done. 3. Review of the provider's 11/11/24 Personnel Training policy revealed: *"The facility shall have a formal orientation program and an ongoing education programs	S 295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 295	Continued From page 7 must cover the required subjects annually. These programs must be completed within 30 days of hire and must 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 must be conducted to provide training for all staff. 2. Emergency procedures preparedness a. Tornado Evacuation Procedure and Report B. Flooding 3. Infection control and prevention a. Handwashing, Handling Soiled Linens & Laundry, Blood-Borne Pathogen, Spill Kit Instructions b. Sufficient supplies and equipment to practice infection control. 4. Accident prevention and safety procedures 5. Resident Rights 6. Confidentiality of resident information 7. Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms (DOH Reportable Diseases Poster) 8. Nutritional risks and hydration needs of residents 9. Abuse, Neglect, Misappropriation of resident property and funds, and mistreatment 10. Tuberculosis Training 11. Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility. 12. Any additional healthcare employees to the residents who are accepted and retained in the facility. Additional personnel education shall be provided based on facility identified Resident specific needs-Diabetes, Oxygen Safety, Wound Care Catheter Care, Suicidal Behaviors, Depression, etc. The Administrator will identify instructors that are appropriately qualified to teach the programmed subject and then schedule them for training. All staff are required to attend the training unless excused by the Administrator. Any staff member missing the instruction will be required to review	S 295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 295	Continued From page 8 the notes and handouts and ask the Administrator any question they may have. A record of training subjects and attendance will be maintained on file for two years and is subject to inspection by the Department of Health."	S 295		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8).	S 296	Employee E received education on the required trainings listed by administrator. Required annual training will be completed by all employees by the administrator or designee. The annual training will include but is not limited to: Fire Prevention and Response Emergency Procedures and Preparedness: Infection Control and Prevention Abuse, Neglect, and Misappropriation Accident Prevention and Safety Procedures Resident Rights Confidentiality of Resident Information Mandatory Reporting Nutrition and Hydration Needs Care for Unique Needs Restraint Use Diabetes New employees will receive mandatory education upon hire and it will be completed within 30 days of hire. Audits will be completed by administrator or designee with each new hire for six months. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 296	Continued From page 9	S 296		

This Administrative Rule of South Dakota is not met as evidenced by:
Based on personnel file review, interview, and policy review the provider failed to ensure the required training was completed within 30 days of hire for one of five recently hired employee (E).

1. Medication Aide (MA) E had been hired on 5/14/25.
*She had not completed training on fire prevention and response, emergency preparedness, infection control and prevention, accident prevention and safety procedures, confidentiality, abuse, neglect, and misappropriation of resident property and funds, and education based on the resident care needs within 30 days of hire.

2. Interview on 11/5/25 at 1:00 p.m. with administrator A revealed:
*She was not surprised that employee training had missing files and stated, she did not know how to get staff to come in get their required training done.

3. Review of the provider's 11/11/24 Personnel Training policy revealed:
*"The facility shall have a formal orientation program and an ongoing education programs must cover the required subjects annually. These programs must be completed within 30 days of hire and must 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 296	Continued From page 10 fire drills must be conducted to provide training for all staff. 2. Emergency procedures preparedness a. Tornado Evacuation Procedure and Report B. Flooding 3. Infection control and prevention a. Handwashing, Handling Soiled Linens & Laundry, Blood-Borne Pathogen, Spill Kit Instructions b. Sufficient supplies and equipment to practice infection control. 4. Accident prevention and safety procedures 5. Resident Rights 6. Confidentiality of resident information 7. Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms (DOH Reportable Diseases Poster) 8. Nutritional risks and hydration needs of residents 9. Abuse, Neglect, Misappropriation of resident property and funds, and mistreatment 10. Tuberculosis Training 11. Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility. 12. Any additional healthcare employees to the residents who are accepted and retained in the facility. Additional personnel education shall be provided based on facility identified Resident specific needs-Diabetes, Oxygen Safety, Wound Care Catheter Care, Suicidal Behaviors, Depression, etc. The Administrator will identify instructors that are appropriately qualified to teach the programmed subject and then schedule them for training. All staff are required to attend the training unless excused by the Administrator. Any staff member missing the instruction will be required to review the notes and handouts and ask the Administrator any question they may have. A record of training subjects and attendance will be maintained on file for two years and is subject to inspection by the Department of Health."	S 296		

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
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 305	Continued From page 11	S 305		
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, and policy review the provider failed to ensure that the health status for communicable diseases were evaluated by a licensed health professional within 14 days of hire for one of five sampled employee (E). Findings include: 1. Review of medication aide (MA) E's personnel file revealed: *Her date of hire was 5/14/25. *Her health evaluation was not in her employee file. 2. The provider's employee 5/18/25 health program policy revealed: *"All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment. 1. Health Questionnaire will be performed by a licensed nurse. 2. 2-step TB skin test will be administered before assignment to duties and then 7-21 days following first skin test if result was negative. 3. Hepatitis B vaccination questionnaire will be	S 305	Employee health policy has been reviewed and revised by the administrator. Employee health questionnaire will be completed for all employees currently employed and new hires by Leisure Living by the nurse consultant. All new employees will receive a 2-step TB test completed, hepatitis B vaccine questionnaire with current VIS. The administrator or designee will complete audits on all employee files utilizing the audit for for S285 tag, then with each new hire for six months. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 305	Continued From page 12 given. Current VIS form will be given for education on the vaccine. Employee can choose to consent to or decline the vaccination. 4. After all forms completed, they will be kept in the employee's file in the Business Office. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease which may endanger the health or residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage."	S 305		
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.	S 506	Administrator has reviewed and revised the dietary in-service policy. Education will be provided by the administrator or designee and will be completed by all employees. Audit will be completed on all education that is completed to ensure it is completed entirely, signed and dated. Audit will be completed with each new employee x 1 year and with the next annual education. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 506	Continued From page 13 This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure the required dietary training was completed within 30 days of hire or annually for three of five employees (C, D, and E) with dietary and food-handling responsibilities. Findings include: 1. Review of registered nurse (RN) C employee personnel records revealed: *She was hired 7/15/21. *There was no documentation to support she had completed any of the required annual. dietary training in 2024 and 2025, as of 11/5/25. 2. Review of MA D was hired 7/29/10. *There was no documentation to support she had completed any of the required annual dietary training in 2024 and 2025, as of 11/5/25. 3. Review of MA E was hired 5/14/25. *There was no documentation to support she had completed any of the required dietary training within 30 days of hire. 4. Interview on 11/5/25 at 1:00 p.m. with administrator A revealed: *She was not surprised that the employee training had missing files and stated, she did not know how to get staff to come in get their required training done. 5. A policy for the provider's dietary in-service training was requested 11/6/25 via email to administrator A when she could not provide documentation to support training had been completed, however, the provider did not have a	S 506		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 506	Continued From page 14 policy.	S 506		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure two of two residents (1 and 2) with diabetes who had been prescribed insulin had a physician's order and an assessment completed to determine their ability to safely self-administer their insulin. Findings include: 1. Observation and interview on 11/4/25 at 11:15 a.m. regarding resident 1's self-administration of her insulin revealed:	S 685	Administrator reviewed and revised self-administration of medication policy. Orders have been received for self-administration of insulin for both resident 1 and resident 2 and are current in their medical record. The registered nurse consultant and Med Aides that provide insulin has been re-educated by the administrator regarding the guidelines of self administration of medication and the assessment required every three months and PRN completed by Registered Nurse. RN has completed assessments and ensured resident 1 and 2 are able to appropriately administer own insulin. Audits will be completed on resident 1 and 2's medical chart to ensure correct order is noted and reflects on the MAR and that assessments are completed as per policy. Follow up audits will be completed every 3 months for 12 months. Administrator or designee will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and further recommendations. At this time, a decision will be made for the audits to either continue or to be resolved.	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 15 *Medication Aide (MA) B set the insulin pen to the correct dose, handed resident 1 the insulin pen and resident 1 self-administered her insulin. *MA B was not aware if resident 1 had an physician's order to self-administer her insulin. *MA B stated she was not aware if resident 1 had an assessment completed to determine is she was able to self-administer her insulin. However, she had observed resident 1 self-administer her insulin. *MA B was not aware if she had special diabetic training to assist in the administration of insulin. 2. Interview on 11/5/25 at 11:15 a.m. with registered nurse (RN) C regarding residents self-administering insulin revealed: *She was not aware that a physician's order was needed for residents to self-administer their insulin or that she needed to evaluate them to safely administer their insulin. *RN C stated resident's 1 and 2 had physician's orders for the insulin however, she did not have physicians orders for those residents to self-administer their insulin. 3. Interview on 11/5/25 at 11:15 a.m. with administrator A revealed she did not have a response to RN C's not knowing she needed to completed a self-administration of medication of medication assessment for residents to self-administer their insulin. 4. Review of resident 1's electronic medical record (EMR) revealed: *She had a physician's order for Humalog 200 units/ML Kwikpen dated 9/11/25 to give 40 units subcutaneously with breakfast 34 units with lunch and 36 units with supper plus sliding scale maximum daily dose 153 units. -She had a physicians's order for Humalog	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41964	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE LIVING HARTFORD	305 W 5TH HARTFORD, SD 57033

(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 16 Kwikpen 200 unit/1ML insulin pen dated 9/16/25 to inject subcutaneously per sliding scale 0-150 none, 151-200 4 units, 201-250 6 units, 251-300 10 units, 301-350 12 units, 351-400 15 units, 401-500 17 units. 5. Review of residents 2's EMR revealed she had a physician's order for Humulin 70/30 Kwikpen dated 8/8/25 to inject 18 units with breakfast and 18 units with supper. 6. The providers 5/11/25 self-administration policy revealed: *"1. Patients may self-administer a medication if there is a valid prescriber's order in the medical record specifically authorizing the process. *"3. Ongoing monitoring of self-administering competency will be documented." -"a. If it is determined that the resident is not competent to administer medication, the nurse consultant or Administrator will contact the physician for an alternative plan."	S 685		