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

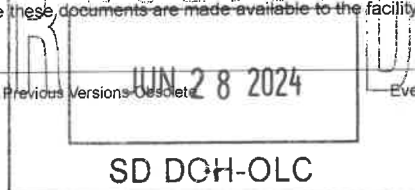
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435083	A. BUILDING ______ B. WING ______	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DR BROOKINGS, SD 57006

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/29/24 through 5/31/24. The Neighborhoods at Brookview was found not in compliance with the following requirements: F725, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/29/24 through 5/31/24. Area surveyed included Quality of Care. The Neighborhoods at Brookview was found in compliance.	F 000		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 725	1. All residents have the potential to be affected. 2. Corrective action to be taken will include re-education of all staff that are able to answer call lights. Education provided will include the importance of timely assistance, anticipating resident needs to reduce calls for assistance and a reminder of our goal of answering call lights within five minutes. DON or designee will meet with staff weekly to discuss the call light report for each Neighborhood. In addition, the call light report will be sent to all staff weekly for review. The report will also be discussed at the monthly Neighborhood meetings. Education will be provided by July 3rd.	7/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeremy Klinkhammer	Administrator	6/20/24

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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F 725	Continued From page 1 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and call light log report review, the provider failed to ensure call lights were answered promptly for one of two sampled residents (29) who used the call light to alert staff of assistance needs. Findings include: 1. Observation and interview on 5/29/24 at 3:55 p.m. with resident 29 revealed: *She stated she had waited for over an hour on a few occasions in the last few months for staff to respond to her call light. 2. Interview on 5/30/24 at 3:35 p.m. with administrator A regarding call light times revealed: *They had budgeted to replace the call light system next year. *It took more deliberate review to utilize the information because of the age of the system. *He was not sure if they could determine staff response times for individual room call lights. 3. Interview on 5/31/24 at 8:32 a.m. with director of nursing B regarding call light times revealed: *The goal was for staff to have answered call lights within an average of five minutes. *She had printed off the requested rooms call light times. *It would have been very labor-intensive to review call light response times by individual rooms. 4. Review of resident 29's call light report from	F 725	3. DON or designee will audit 5 random resident call lights weekly for 2 months and then monthly for 3 months. DON or designee will bring results to the QAPI meeting for further review and recommendation to conitnue or discontinue.	

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F 725	Continued From page 2 3/1/24 to 5/30/24 revealed: *There were 82 times when over 20 minutes had passed until the staff responded to her call light. *The longest call light response wait time was one hour and 21 minutes. 5. Interview on 5/31/24 at 1:12 p.m. with certified nursing assistant H regarding call lights revealed: *He had a walkie-talkie that notified him when a call light was activated. *He would also get notified when a call light was answered. *The goal was to answer all call lights within five minutes. 6. Interview on 5/31/24 at 2:33 p.m. with nursing supervisor I regarding call light times revealed: *The goal was to average less than five minutes for call lights to be answered by staff. *They reviewed call light times during monthly quality assurance meetings. *If they noticed an issue, they would have reviewed call light response times more closely. 7. Interview on 5/31/24 at 3:18 p.m. with the DON B regarding the quality assurance and performance improvement (QAPI) program and call light response times revealed: *The QAPI committee met monthly. *The medical director attended quarterly. *They had a performance improvement plan (PIP) in place for call light times. *Call light reports were emailed to administration weekly for review. *The goal was for staff to answer a resident's call light within 5 minutes. *The report can be compiled by resident room but must be counted manually for an average time to be calculated. *They have had problems with the current call	F 725		

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F 725	Continued From page 3 light system, but it was to be updated soon. A call light policy was requested on 5/31/24 DON B stated they did not have a call light policy.	F 725		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, expiration date cheat sheet review, and policy review, the provider failed to properly label and store: *Juice cartons in two of six kitchenette refrigerators. *Food items in one of one main kitchen walk-in cooler. Findings include: 1. Observation and interview on 5/30/24 at 9:14	F 812	1. All residents have the potential to be affected. 2. Corrective action will consist of re-education for all dietary staff and nursing staff who have access to the household kitchens. Re-education will include reviewing the updated Sanitation in Food Handling Standard Operation Procedure and direct observation of understanding expiration dates and proper labeling of opened food items. The updated SOP will include adding procedures for food storage and discarding of expired food items. 3. Dietary manager or designee will audit 5 random refridgerators weekly for 4 weeks and then monthly for 4 months to ensure all items are dated correctly and expired items are discarded. Dietary manager or designee will bring results to the QAPI meeting for further review and recommendation to continue or discontinue.	7/15/24

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F 812	Continued From page 4 a.m. with nutrition and food service worker E in the Ash Boulevard neighborhood kitchenette revealed: *A side-by-side refrigerator with several fruit juice cartons on the top two shelves. *A grape juice carton in the refrigerator was dated 5/17/24 and 5/24/24. *Food service worker E explained the first date was when the carton was opened. -The second date on the carton is considered the expiration date once it was opened. -Sometimes the juice is still good after one week. -She would taste the juice to ensure it was still good before serving it if it was after the expiration date. -She agreed the grape juice was expired. 2. Interview on 5/30/24 at 9:52 a.m. with food service worker F revealed: *When they open any food or beverage product, they write the date on it so they know when it was opened. *They count out seven days and write that date on it and that is the expiration date. 3. Observation and interview on 5/30/24 at 10:38 a.m. with nutrition and food service worker G in the Birch Way neighborhood kitchenette revealed: *A side-by-side refrigerator with several fruit juice cartons on the top two shelves. *A grape juice carton in the refrigerator was dated 5/19/24 and 5/26/24. *An apple juice carton in the refrigerator was dated 5/17/24 and 5/23/24. *She stated they label resident food and drink items when they are opened. -They put a second date on the package dated a week later that would be considered the	F 812		

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F 812	Continued From page 5 expiration date. -Items would be discarded after the expiration date. *She agreed the cartons of grape juice and apple juice had expired and should have been thrown away. 4. Observation on 5/30/24 at 2:02 p.m. in the walk-in cooler in the main kitchen revealed: *An open package of smoked gouda cheese wrapped in plastic cling wrap dated 5/1 and 5/15. *A package of bacon bits wrapped in plastic cling wrap dated 5/2 and 5/22. *Three unopened gallons of vitamin D milk with a best by date of 5/29/24. 5. Interview on 5/31/24 at 1:41 p.m. with nutrition and food supervisor D in the main kitchen revealed: *They had an expiration date cheat sheet to follow for the expiration dates for food and beverage items once opened. *The cheat sheet was not all-inclusive. *She thought the smoked gouda cheese was categorized with parmesan cheese and expired 30 days after it was opened. *She stated the three gallons of milk had another seven days past the best by date according to the label. -She went into the main kitchen walk-in cooler. -Looked at a gallon of milk label. -There was nothing on the label that indicated milk was good for seven days past the best by date. *She would have expected staff to have labeled food items when opened and to have followed the expiration dates on the cheat sheet. *She agreed staff should not have been tasting juice to ensure quality if it had been open more	F 812		

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F 812	Continued From page 6 than seven days. *She stated the juice cartons and bacon bits were past their expiration date and should have been discarded. 6. Review of the provider's 3/22/21 Expiration Date Cheat sheet revealed: *"Milk-2%, Whole date on package, up to 7 days past date on package." *"Cheese-Parmesan date on package, 30 days once opened." *"If not listed 7 days." 7. Review of the provider's June 2013 Sanitation in Food Handling policy revealed: *"Storage of perishable items... 7. Opened packages of commercially packaged foods are bagged, dated and immediately frozen and stored in the Main Kitchen Freezer. Staff can then pull individual packages as needed and date them 5 days from the date they pulled them to expiration." *"D. Expired/Outdated Product Any product expired or outdated will be removed from shelf/refrigeration/etc. and properly disposed of."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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F 880	Continued From page 7 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	1. All residents have the potential to be affected. 2. Corrective action will consist of re-education for all staff that handle linens and all staff that provide catheter care. Education will include reviewing linen handling Standard Operating Procedure, teach back(which means to have the employee explain the information back and listen critically for errors in understanding), and direct observation of understanding linen handling Standard Operating Procedure. In addition, re-education will include reviewing catheter care Standard Operating Procedure and Infection Control Program that contains hand hygiene methods, teach back, and direct observation of understanding the Standard Operating Procedure. The education will be provided by July 3rd. Proactive ICAR was completed on 6/20/24. CDC Project Firstline training was also completed on 6/20/24. 3. Infection Preventionist or designee will audit 5 random Neighborhoods for compliance with linen transfer each week for 4 weeks and then monthly for 3 months. Infection Preventionist or designee will audit 5 catheter cares weekly for 4 weeks and then monthly for 3 months. Infection Preventionist or designee will bring results to the QAPI meeting for further review and recommendation to continue or discontinue.	7/15/24

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F 880	Continued From page 8	F 880		

contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
A. Based on observation, interview, and policy review, the provider failed to ensure appropriate glove use and hand hygiene had been performed during one of two residents (44) observed catheter care and personal care by certified nursing assistant (CNA) J.
Findings include:

1. Observation and interview on 5/30/24 at 8:35 AM of catheter care for resident 44 by CNA J revealed:
* CNA J had a gown and gloves on when the surveyor entered resident 44's room.
*With those gloved hands she:
-Held a pen, moved the call light, and bedding, and touched the sink faucets.
-Prepared for catheter care by opening a wet wipe packet, removing wipes, and cleansing the resident's perineal area, including the the area around the catheter entrance with no-rinse soap and water.

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F 880	Continued From page 9	F 880		

-Stated she cleansed around the catheter with no-rinse soap and water, and cleansed only at the entrance of the catheter tubing.
-Removed the resident's brief and cleansed her buttocks and rectum with wet wipes.
*With those same gloved hands she walked to the bathroom, opened and closed a cabinet two times, and removed a clean brief and skin cream from the cabinet.
-Applied the skin cream on the resident's buttocks, removed the glove from her right hand, and put a clean glove on the right hand, and without washing her hand she put a clean glove on her right hand.
-She did not remove the soiled glove from her left hand.
--She then put lotion on her legs, and removed both gloves.

2. Interview on 5/31/24 at 3:30 p.m. with director of nursing (DON) B regarding the observed glove use and lack of hand hygiene revealed CNA J should have washed her hands or used hand sanitizer before she had put gloves on, and after she had removed gloves.

3. Review of the provider's October 2013 Infection control program policy regarding hand hygiene revealed:
*Hand hygiene:
-Was the single most important method of preventing the spread of infection.
-Removes dirt, organic and inorganic materials, and transient microorganisms.
-During patient care was necessary to remove microcontamination from recent contact with infected, colonized patients or environmental sources.
*The use of gloves was not a substitute for hand

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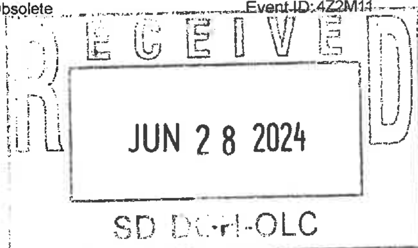
F 880	Continued From page 10 hygiene. *Care givers should perform hand hygiene: -Before and after contact with the patient or environment. -After contact with a source of microorganisms. -After removing gloves, masks, or other protective gear. *Alcohol-based hand sanitizer should have been used in conjunction with soap and water and not the sole source of hand hygiene. B. Based on observation, interview, and policy review, the provider failed to ensure residents' clean laundry had been covered when delivered to resident's rooms by one of one CNA (J) observed during laundry pass. Findings include: 1. Observation and interview on 5/31/24 at 9:30 a.m. with CNA J while walking down Elm hall with a laundry cart revealed: *The cart had a place to hang clothing on hangers. *The cart was not covered and left the laundry at risk of contamination. *CNA J stated she had worked for the provider for over two years and had never heard anyone state the laundry was to have been covered while it was in the hallway. 2. Interview on 5/31/24 at 3:00 p.m. with CNA K regarding covering the residents' laundry while delivering the laundry sometimes the CNAs cover it, and sometimes they had not covered it. 3. Interview on 5/31/24 at 3:30 p.m. with the DON B regarding delivering resident laundry revealed she did not know the laundry had been delivered uncovered. The laundry should have been	F 880		



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F 880	Continued From page 11 covered. 4. Review of the provider's revised March 2024 Infection Control Practices policy revealed: *Staff could use a clean cart to deliver laundry and would leave the cart outside of the room to ensure appropriate hand hygiene. *If the carts were not used staff will carry laundry away from their uniforms so it did not contaminate the clean laundry. *Staff would cover laundry during deliveries.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 5/29/24 through 5/31/24. The Neighborhoods at Brookview was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremy Klinkhammer
TITLE: Administrator
(X6) DATE: 6/20/24

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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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
	435083	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**05/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	**2421 YORKSHIRE DR** **BROOKINGS, SD 57006**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/29/24. The Neighborhoods at Brookview 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 the deficiency identified at K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain egress paths free of hazards for 2 of 15 exits (north exit of Ash Boulevard and the north exit of Oak Lane). Findings include: 1. Observation at 12.29 p.m. on 5/29/24 revealed the path of egress for the north exit of Ash Boulevard had an abrupt level change in the path of egress greater than one-half of one inch. 2. Observation at 12.29 p.m. on 5/29/24 revealed	K 211	1. All residents have the potential to be affected in Ash and Oak lane. 2. Concrete will be fixed to provide a pathway free of hazards and a level walkway. 3. Administrator or designee will audit walk ways weekly for 1 month and then monthly for 3 months. Administrator or designee will bring the results of the audits to the QAPI meeting for further review and recommendations to continue or discontinue.	7/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeremy Klinkhammer	Administrator	6/20/24

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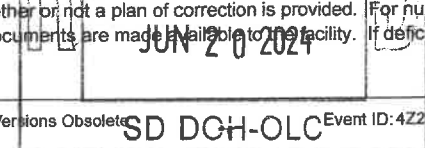
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435083	A. BUILDING 01 - MAIN BUILDING B. WING	05/29/2024

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THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DR BROOKINGS, SD 57006

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K 211	Continued From page 1 the path of egress for the north exit of Oak Lane had deteriorated concrete creating a less than nominally level walking surface in the path of egress. LSC 7.1.6.3(1) Interview with the environmental services director at the same time as the observations confirmed those conditions. He stated he was new and had not been made aware of those conditions. The deficiencies had the potential to affect 100% of the smoke compartment's occupants.	K 211		

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
	10600	A. BUILDING: ____ B. WING ____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DRIVE BROOKINGS, SD 57006

(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/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/29/24 through 5/31/24. The Neighborhoods at Brookview was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeremy Klinkhammer	Administrator	6/20/24