

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

FORM APPROVED

OMB NO. 0938-0391

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>435083</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>11/21/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>THE NEIGHBORHOODS AT BROOKVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR , BROOKINGS, South Dakota, 57006</b>			
(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
F0000	INITIAL COMMENTS			F0000			
F0921 SS = D	<p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/16/25 through 9/18/25. The Neighborhoods at Brookview was found not in compliance with the following requirement: F921</p> <p>Safe/Functional/Sanitary/Comfortable Environ</p> <p>CFR(s): 483.90(i)</p> <p>§483.90(i) Other Environmental Conditions</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and policy review the provider failed to ensure a safe environment when the oven in Ash Neighborhood kitchenette was left on at 300 degrees and unattended by nutrition services (NS) D with four residents observed in he area.</p> <p>Findings include:</p> <p>1. Observation on 9/16/25 at 9:36 a.m. of the Ash Neighborhood revealed:</p> <p>*There was an odor that indicated something like an oven was hot.</p> <p>*There were no staff observed in the kitchenette area.</p> <p>*There were covered unbaked cookies on cookie sheets on the stove and countertop.</p> <p>*The ovens digital temperature light was on and indicated it was at a temperature of 300 degrees.</p> <p>*The oven door was not locked and opened easily. The oven was empty and hot.</p> <p>*There were four residents (19,33,44,56) observed in the dayroom near that kitchenette area.</p>			F0921	<p>1. All residents have the potenital to be harmed.</p> <p>2. Corrective action to be taken will include re-education of all dietary staff and updating policy to include use of oven in the kitchenette space. Dietary Supervisor will meet with all dietary staff to over education and update policy</p> <p>3. Dietary Supervisor or designee will audit oven usage/process 3 times weekly for a month and then monthly for an additional 3 months. Dietary Supervisor will bring the results to the QAPI meeting for further review and recommendations to continue or discontinue.</p>		12/5/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeremy Klinkhammer</i>	TITLE Administrator	(X6) DATE 11/28/2025
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<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>435083</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>11/21/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>THE NEIGHBORHOODS AT BROOKVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR , BROOKINGS, South Dakota, 57006</b>			
(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
F0921 SS = D	<p>Continued from page 1</p> <p>*One staff member had entered that area and left with one resident.</p> <p>2. Review of residents 19s electronic medical record revealed she had scored a score of 15 on her brief interview for mental status (BIMS) that indicated she was cognitively intact.</p> <p>3. Review of resident 33's EMR revealed she had scored 00 for her BIMS that indicated she had severe cognitive impairment.</p> <p>4. Review of resident 44's EMR revealed she had scored 01 for her BIMS that indicated she had severe cognitive impairment.</p> <p>5. Review of resident 56's EMR revealed she had scored 15 for her BIMS that indicated she was cognitively intact.</p> <p>6. Interview on 9/16/25 at 9:42 a.m. with NS D when she entered the Ash Neighborhood kitchenette area regarding the oven revealed, she confirmed the oven was on at temperature of 300 degrees and agreed someone should have monitored the oven while it was on and residents were in the area. She then stated she told the cook in the galley she was stepping away for a bit and he would have monitored it from the that galley kitchen.</p> <p>7. Interview on 9/16/25 at 9:45 a.m. with dietary cook E in the galley kitchen revealed he thought the oven should be off if residents were in the area and no staff were there to monitor the oven. He did not state he had been monitoring that oven.</p> <p>8. Interview on 9/16/25 at 9:46 a.m. with nurse supervisor/registered nurse (RN) C regarding the kitchenette oven revealed it was NS D's responsibility to stay right by the stove when it was on or when she was using it.</p> <p>9. Interview on 9/16/25 at 9:50 a.m. with food services director (FSD) B revealed:</p> <p>*She had a general safety policy but did not have a specific policy regarding neighborhood kitchenette ovens.</p> <p>*She stated, "that it was the understanding that if the oven was on that it would be monitored by staff." She stated she could add that to their current general safety policy.</p>			F0921			

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NAME OF PROVIDER OR SUPPLIER <b>THE NEIGHBORHOODS AT BROOKVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR , BROOKINGS, South Dakota, 57006</b>			
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F0921 SS = D	<p>Continued from page 2</p> <p>10. Interview on 9/18/25 at 10:30 a.m. with administrator A revealed, he had entered that kitchenette area on 9/16/25 during the above noted observations and did not see NS D in that area at that time. He stated he did not see anyone next to the stove and that no one was hurt. He stated the cook should have watched the oven when NS D was away from the area when the oven was on.</p> <p>11. .Review of the provider's November 2024 General Facility Safety policy revealed:</p> <p>"It is the goal of the Brookings Hospital and neighborhoods @ [at] Brookview to provide a safe facility and grounds for its patients, residents, visitors, and staff. Safety is everyone's responsibility and requires the cooperation and diligence of every employee."</p>			F0921			



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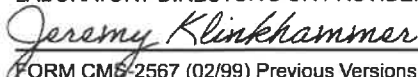
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<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>435083</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>11/21/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>THE NEIGHBORHOODS AT BROOKVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR , BROOKINGS, South Dakota, 57006</b>			
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E0000	<p>Initial Comments</p> <p>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 on 9/17/2025. The Neighborhoods at Brookview was found in compliance.</p>			E0000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

11/25/2025



<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>435083</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING</b> B. WING		(X3) DATE SURVEY COMPLETED <b>11/21/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>THE NEIGHBORHOODS AT BROOKVIEW</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR , BROOKINGS, South Dakota, 57006</b>			
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K0000  Bldg. 01	INITIAL COMMENTS  A recertification survey was conducted on 9/17/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. The Neighborhoods at Brookview was found in compliance.			K0000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeremy Klinkhammer</i>		TITLE Administrator	(X6) DATE 11/25/2025
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10600</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>09/18/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DRIVE BROOKINGS, SD 57006</b>		
(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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/16/25 through 9/18/25. The Neighborhoods at Brookview was found in compliance.	S 000			
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 9/16/25 through 9/18/25. The Neighborhoods at Brookview was found in compliance.	S 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Jeremy Klinkhammer*  
STATE FORM

Administrator

11/25/2025

6899

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If continuation sheet 1 of 1

