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
	80023	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - MILBANK	410 E 10TH AVENUE MILBANK, SD 57252

(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 on 4/14/25 through 4/16/25. Peaceful Pines Senior Living - Milbank was found not in compliance with the following requirements: S085, S169, S201, and S632. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 4/14/25 through 4/16/25. Areas surveyed included resident neglect, nursing services, and a resident death. Peaceful Pines Senior Living - Milbank was found not in compliance with the following requirement: S337.	S 000		
S 085	44:07:02:03 Cleaning Methods And Facilities The facility shall have supplies, equipment, work areas, and complete written procedures for cleaning, sanitizing, or disinfecting all work areas, equipment, utensils, and medical devices used for residents' care. Common-use equipment shall be disinfected after each use. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and review of the manufacturer's instructions for use for Non-Acid Restroom Disinfectant/Cleaner, the provider failed to mix the Non-Acid Restroom Disinfectant/Cleaner according to the manufacturer's instructions for the disinfection of one of one whirlpool tub. Findings include:	S 085	The Executive Director posted the correct guidelines for Non-Acid Restroom Disinfectant/Cleaner per manufacturer's instructions for cleaning whirlpool tub on 4/17/2025. ED/DON provided education training to all care staff on how to properly clean the whirlpool per manufacturer's i nstructions on Hillyard Non-Acid D isinfectant/Cleaner. Educated staff on 4/17/2025. A cleaning checklist was created on 4/17/2025 by ED. During the education and training meeting, the ED/DON i nstructed that all care staff must clean the whirlpool after each resident uses and upon completion complete the cleaning checklist for the whirlpool tub as part of the auditing process. ED/DON will monitor and audit the process until the end of December 2025. Results of the whirlpool tub audit will be shared at the each monthly QAPI meeting through December 2025	4/17/2025

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

Executive Director — 6/11/2025

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S 085	Continued From page 1 1. Observation on 4/15/25 at 12:10 p.m. in the whirlpool room revealed: *A residential style whirlpool had been installed. *The whirlpool was not equipped with an internal disinfection system. *To cover the jets with water the tub would need to be filled. *To fill the tub full enough to cover the jets would take approximately 25 gallons of water. Interview on 4/15/25 at 12:15 p.m. with resident care assistant (RCA) C revealed: *She had been instructed to clean the whirlpool tub by filling the tub full of water above the top jets. *She would add a half of a cup (4 ounces.) of Non-Acid Restroom Disinfectant/Cleaner to the tub. *She would then run the jets for ten minutes. Review of the manufacturer's instructions for use for Non-Acid Restroom Disinfectant/Cleaner revealed: "To disinfect inanimate, hard non-porous surfaces add 2 ounces of Non-Acid Restroom Disinfectant/Cleaner per gallon of water. Interview on 4/15/25 at 12:20 p.m. with executive director A and RCA C revealed they were not aware the Non-Acid Restroom Disinfectant/Cleaner was not being mixed according to the manufacturer's instructions for use for disinfecting the whirlpool tub.	S 085		
S 169	44:70:02:17(5) Occupant Protection The facility shall:	S 169		

Heidi Sinclair

Executive Director

6/11/2025

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S 169	Continued From page 2 (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the license, observation, testing, and interview the provider failed to install electrically activated audible alarms on four randomly observed unattended exit doors (the front door, the exterior exit door located by central supply, and the two interior exit doors to the independent living building.) Findings include: 1. Review of the current license revealed the facility was licensed for the care of cognitively impaired residents. That service requires the provider to install electrically activated audible alarms on all unattended exit doors. 2. Observation and interview on 4/15/25 at 11:25 a.m. of the exterior exit door located by central supply with executive director (ED) A revealed: *That door was not equipped with an electrically activated audible alarm. *She knew that door was not alarmed. *She did not know why that door was not alarmed. *She agreed it should have an alarm that sounded when the door was opened. 3. Interview on 4/15/25 at 11:25 a.m. regarding the front entrance door with ED A revealed: *The front entrance door was not equipped with	S 169	PPSL Milbank will request that the cognitive impairment optional service only apply to those residents residing on the memory care unit by May 31, 2025. Prior to admission, the DON will conduct a cognitive assessment using either the Brief Interview for Mental Status or Saint Louis University Mental Status screening tool. Based on the assessment findings, the DON, ADON, ED, or designee will conduct a care conference with the resident, family and power of attorney to discuss potential transition from assisted living to memory care. DON will review the prospect's medical history and physical diagnosis to assist in determining the appropriate service Line. Per our policy: To ensure residents are accurately diagnosed and treated for cognitive impairment, a diagnosis within the category of Alzheimer's Disease or related dementias (ADRD) by qualified health professional will be considered cognitively impaired. Following an accurate diagnosis by a qualified health processional, Peaceful Pines will work with the resident and/or family to determine appropriate placement within the service line recommended by the qualified health professional. Regarding current residents, staff will monitor residents regularly for signs of cognitive decline, through routine screenings per South Dakota Rules and Regulations. If questionable, decline is observed, a cognitive assessment referral will be repeated for accurate testing and diagnosis, and treatment. Scoring within range of cognitive impairment on screening tools will trigger a referral for an additional assessment by a qualified health professional. A qualified health professional will need to diagnosis an individual with cognitive impairment. Screening tools, such as those used by staff at Peaceful Pines, are use d for screening and not diagnosis of cognitive impairment in individuals. In the even that a medical professional indicates a diagnosis within a category of Alzheimer's Disease or Related Dementia's, ED and DON, or delegate will work with family to determine appropriate placement and transition to memory care. If resident(s)/ family or physician declines transition to the memory care unit, PPSL- Milbank will work with the resident/family/POA with discharge planning. All staff receive dementia training on care, behavior management, and intervention strategies to support residents with cognitive impairments yearly. The DON, ADON, ED, or designee reviewed list of residents' cognition diagnoses and cognition scores ensuring appropriate transitions (if necessary) were completed by May 31, 2025. DON, ADON, ED or designee to discuss findings and resident outcomes/recommendations at facility's monthly QAPI meetings to evaluate effectiveness and make necessary adjustments. The QAPI committee will oversee implementation, conducting regular audits to ensure compliance. The corrective measures outlines will be fully implemented were May 31, 2025. If a resident(s)/family or physician declines admission to memory care unit, PPSL-Milbank will work with the resident/family/POA with discharge planning.	5/31/2025

Heidi Sinclair Executive Director 6/11/2025

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S 169	Continued From page 3 an electrically activated audible alarm. *She did not know why the front entrance door was not alarmed. *She agreed it should have an alarm that sounded when the door was opened. 4. Observation, testing, and interview on 4/15/25 at 11:30 a.m. of the door going into the west entrance of the independent living with ED A revealed: *That door was not equipped with an electrically activated audible alarm. *It was equipped with a "geofence" (a virtual boundary system) that would alert staff when an assisted living resident carrying a pendant walked into the independent living. -The alert would go to the staff phone and staff could see where each assisted living pendant was in the assisted living and the independent living building. *When an assisted living resident with a pendant walked into the independent living they had access to three exterior exit doors. -The three exterior exit doors in the independent living were not alarmed and the geofence would not alert staff if assisted living residents went out of the building. *Assisted living residents were allowed to walk the halls for exercise in the independent living. *If an assisted living resident did not have their pendant with them the geofence would not alarm if that resident walked into the independent living area of the building. 5. Observation and interview on 4/15/25 at 11:30 a.m. of the door going into the east entrance of the independent living with ED A confirmed: *The east entrance to the independent living was set up the same as the west entrance to independent living.	S 169		

Heidi Sinclair Executive Director 6/11/2025

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S 169	Continued From page 4 *It was not equipped with an electrically activated audible alarm but had a geofence. *Residents who entered the independent living had access to exterior doors that were also not equipped with electrically activated audible alarms. *If an assisted living resident did not have their pendant with them, the geofence would not alarm if that resident walked into the independent living. *She agreed the assisted living residents could walk out of the independent living building without an alarm triggering and without staff's knowledge. *She agreed if a resident did not have their pendant with them, the geofence would not alarm when an assisted living resident walked into the independent living building. *She agreed they were not in compliance with the requirements for the care of cognitively impaired residents.	S 169	On 4/23/2025, the automatic locks were installed on all four sliding doors by Glass Products. The sliding doors are now equipped with a locking mechanism that each residents fob or pendant will be able to unlock the door. All sliding doors are equiped with egress centers that will breakaway from the inside when pushed with force. All staff were educated on how to turn on the automatic locking on the sliding doors. ED has placed a work order on 4/24/2025 to remove deadbolts off the sliding doors. Deadbolts were removed from the all the sliding doors on 5/8/2025. The Maintenance director /ED/ Care staff will complete daily audits on each shift to inspect the doors are locking properly per each shift. This will be a per shift audit for 8 weeks, then weekly audit with no end date to ensure the doors are working properly.	5/8/2025
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 and interview, the provider failed to ensure four of four automatic sliding exit doors were available for emergency egress at all	S 201		

Heidi Sinclair Executive Director 6/11/2025

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S 201	Continued From page 5 times when the building was occupied. Findings include: 1. Observation, testing, and interview on 4/15/25 at 1:00 p.m. of the east automatic sliding exit door from the assisted living with executive director (ED) A and maintenance director D revealed: *The power for the sliding door had been shut off because they felt the door was opening too frequently when motion was detected outside of the building. *The door was not equipped with a handle to slide the door. *Attempts to slide the door open revealed the door would not open. *The maintenance director turned on the power to the automatic opener, but the door did not open. *Further observation revealed the door was equipped with a small knob that when turned operated a lock. -The knob to the lock was approximately one inch wide and one inch tall. It was just big enough to grasp between your thumb and index finger and twist. -The knob and door where the same color of black and the knob was not easy to see. *There was a note approximately four inches wide and two inches tall taped to the glass on the door. -The note stated in red lettering "FOR EMERGENCY EXIT:" -In black lettering "TURN KNOB LEFT TO UNLOCK AND SLIDE DOOR OPEN TO EXIT" *Twisting of the knob released a hook locking mechanism that locked into a slot in the steel door frame. *When the lock was disengaged the door opened with the automatic opener. -The door could be slid open manually if the	S 201		

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S 201	Continued From page 6 power to the automatic opener was turned off. *The door was also equipped with an emergency breakaway feature. -If a person pushed on the door, it would disengage from the track, and then could be swung to an open position, allowing people to exit. *When the lock was engaged into the steel frame, the emergency breakaway feature would not work, and the door could not be opened. *The lock was engaged every night from 10:00 p.m. to 6:00 a.m. to prevent people from entering the building. *The front entrance and two entrances into the independent living building had sliding doors that were equipped with the same lock. *All four of those doors were locked at night from 10:00 p.m. to 6:00 a.m. *They were not aware that exit doors could not be locked from egress when the building was occupied. *They agreed it would not be safe to have locked doors if emergency egress from the building was needed.	S 201	On 4/28/2025 DON, ADON and ED provided education to all care staff on entering incident reports into PCC for injuries. All staff were educated to promptly report any injuries or resident concerns to DON, ADON, on call nurses or designee. ADON, DON, & On Call nurses were re-educated on notifying residents physician of injuries or change in condition the next working business day or sooner if necessary. Nursing staff educated on documentation for all calls received while on -call. All nurses and care staff reviewed change of condition policy and how to handle change in conditions. In addition, DON, ADON,ED or designee will complete weekly (or as needed) reviews of high priority progress notes, and incidents entered by staff in PCC until 12/31/2025 to ensure each residents well-being and safety are addressed properly and in a timely manner. Furthermore DON, ADON, or designee will track physician notification of incidents or change of condition and service plan updates weekly through 12/31/2025. A weekly audit of the PCC dashboard to review high priority progress notes and resident alerts will be conducted through 12/31/2025 to ensure compliance. Further action to be taken by nurse as necessary depending on results. Audit results will be shared at the facilities next monthly clinical QAPI meeting 4/28/2025 Change of condition policy was reviewed by the leadership team on 4/28/2025. But no revisions were made to the policy.	4/28/2025
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to implement the following for one of one sampled resident (1) who	S 337		

Heidi Sinclair Executive Director 6/11/2025

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S 337	Continued From page 7 sustained a serious skin wound: *Thoroughly investigate the source and put interventions into place for the resident's safety. *Notify the resident's primary care physician of his change in condition. *Update the service plan to reflect his current needs. Findings Include: 1. Review of resident 1's care record revealed: *He was admitted on 10/25/24. *His diagnoses included congestive heart failure, atrial fibrillation, hypertension, and stage IV chronic kidney disease. *His 12/3/24 Brief Interview for Mental Status (BIMS) assessment score was 11,which indicated he had moderate cognitive impairment. *On 3/15/25, he sustained a 2.5 centimeter in length by 0.5 centimeter in width skin wound identified as a cut to the inside of his left wrist. Continued review of resident 1's care record involving the wound to his left wrist and increased agitation from 3/14/25 - 3/17/25 revealed: *On 3/14/25 staff reported that the resident wanted them to pick him up and put him into his wheelchair. -Staff encouraged resident 1 to participate in his care and he responded with inappropriate language. *On 3/15/25 at approximately 11:00 a.m. he told staff that he was trying to open a box with a knife and it slipped and cut his left wrist. *Staff initially observed the cut to have been covered by the resident with paper towels, tape, and rubber bands. -He allowed the cut to be redressed by staff with a non-sticky dressing and triple antibiotic ointment. *Staff encouraged him to be seen in the emergency room (ER) on 3/15/25 and 3/16/25 for	S 337		

Heidi Sinclair Executive Director 6/11/2025

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S 337	Continued From page 8	S 337		

assessment of the wound but he refused.
-The resident initially stated that he would be seen in the clinic on Monday, 3/17/25 but later refused.
*On 3/16/25, he told staff that he had sustained the wound on his wrist during an attempt to cut cheese which was different than his statement on 3/15/25.
*On 3/16/25, he refused all meals and stated the food was disgusting.
*On 3/17/25, executive director (ED) A and registered nurse/director of nursing (RN/DON) B attempted to discuss with him the weekend's events.
-He declined the discussion stating there were no issues over the weekend.
-He would not let RN/DON B evaluate the wound to his wrist.
-He requested ED A and RN/DON B leave his room.
*There was no documentation to support that the resident's physician had been notified of his increased agitation or the wound to his left wrist.

Interview on 4/15/25 at 10:25 a.m. with unlicensed medication aide (UMA) F regarding resident 1 revealed:
*On 3/15/25, resident 1 requested that UMA F redress his wound that had been covered with paper towels and tape.
-He told her that he had been cutting cardboard.
*She was concerned the cut may have been related to self-harm and shared her concern with licensed practical nurse (LPN) E who was on-call.

Interview on 4/16/25 at 3:00 p.m. with ED A and RN/DON B regarding resident 1 revealed:
*On the morning of 3/17/25, they had attempted to visit with the resident regarding his increased agitation, complaints about staff assistance and

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S 337	Continued From page 9	S 337		

food, and the wound to his wrist.
-He declined to visit with them, to be seen at the clinic, or to allow the wrist wound to be visualized.
*He did not allow RN/DON B to visualize and redress the wound until 3/18/25.
*ED A and RN/DON B had been told by the resident that he obtained the wound while using scissors.
*The resident and his environment were not evaluated for safety risks that could have still been in place after the wound occurred.
*His physician had not been notified regarding the resident's wound and increased agitation.
*His service/care plan had not been updated to reflect his increased agitation or the wound to left his wrist.

Interview on 4/16/25 at 3:50 p.m. with LPN E regarding resident 1's skin wound sustained on 3/15/25 revealed:
*She had been the nurse on-call that weekend.
*The staff working on 3/15/25 had notified her of the resident's increased agitation and the wound to his left wrist.
-UMA G stated she had been told by the resident that he was cutting cardboard.
-UMA F shared her concern that the resident may have cut himself on purpose.
--LPN E stated she shared that information with RN/DON B but did not record the date/time she had done that.
*She requested staff check on the resident frequently throughout the weekend.

Review of the provider's 8/1/23 Change in Condition policy revealed:
*"Change in Condition: The resident has had a change from their baseline health or function. Observations that may indicate a change in

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S 337	Continued From page 10 condition may include changes in mental or physical function, abnormal vital signs, increased or new behaviors...." *"Licensed or Registered nurse will evaluate all residents with condition changes and ensure their needs can be met in assisted living." *"a. If the nurse is not in the building, the nurse will give the unlicensed staff direction as to what immediate treatment or monitoring should be implemented, which may include....Notification of provider....Evaluation by provider (non-emergent). *"The nurse will complete evaluations and update the service plan as needed for significant changes in condition." Review of the provider's 7/15/22 Abuse and Neglect Investigation and Reporting policy revealed: *"Neglect - The absence of the minimal services or resources required to meet [a resident's] basic need[s]. Neglect includes withholding or inadequately providing medical care and, consistent with usual care, treatment, and services....It may also include placing an individual in unsafe and unsupervised conditions."	S 337		
S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's	S 632	On 4/17/2025, DON conducted medication cart audits in Assisted Living and Memory Care. All medication bottles inspected, orders in residents MAR confirmed, labeled with first and last name and sticker from AVERA pharmacy placed over all the over -the- counter medications brought in by residents/ families stating " See MAR for directions". Education provided to all care staff that all medications brought in over the counter must be given to a nurse prior to using for administration to ensure proper labeling and orders before placed in medication carts. ADON, DON or designee to complete weekly aduits for 8 weeks and then return to monthly medication cart audits for continued maintenance and compliance. Audit results will be shared at facilities monthly clinical QAPI meeting.	4/17/2025

Heidi Sinclair Executive Director 6/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80023	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - MILBANK	410 E 10TH AVENUE MILBANK, SD 57252

(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 632	Continued From page 11 physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. 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 medications were properly labeled in two of two medication carts (assisted living and memory care) for six of six randomly observed residents' (3, 9, 10, 11, 12, and 13). Findings include: 1. Observation and interview on 4/16/25 at 10:35 a.m. with registered nurse/director of nursing (RN/DON) B of the medication cart located on the assisted living wing revealed: *The top drawer of the medication cart contained medications for residents 3, 9, 10, and 11. -Resident 3's name was written in permanent marker on a bottle of Tylenol PM. -Resident 9's name was written in permanent marker on three boxes of cranberry caplets. -No name was on a bottle of Mucus ER caplets. --RN/DON B stated the medication belonged to resident 10. -Resident 11's name was written in permanent marker on a bottle of extra strength acetaminophen and a package of Mucus R (relief). *There were no labels on the bottles or packages that provided instructions for the administration of those medications related to a physician's order. 2. Observation on 4/16/25 at 10:45 a.m. of the medication cart located in the memory care unit revealed:	S 632		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 632	Continued From page 12 *The top drawer of the cart contained medications for residents 12 and 13. -Resident 12's name was written in permanent marker on a box of Salonpas (lidocaine) patches. -Resident 13's name was written in permanent marker on a bottle of extra strength acetaminophen, a bottle of generic ibuprofen, and a bottle of Motrin IB (ibuprofen). *There were no labels on the bottles or box that provided instructions for the administration of those medications related to a physician's order. Interview on 4/16/25 at 3:00 p.m. with RN/DON B regarding medication labeling revealed: *The family members of several of the residents had bought the over-the-counter medications and provided them to the facility. *She acknowledged the medications should have had labeling to have indicated who it was for and how often they were ordered to take the medication. Review of the provider's 8/1/22 Security and Accountability of Medications policy revealed it did not address the identification and labeling of over-the-counter medications.	S 632		