STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80607	A. BUILDING: _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - HURON	1714 OHIO NW HURON, SD 57350

(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 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 11/19/24. Areas surveyed included abuse and neglect and nursing services related to accidents. Peaceful Pines Senior Living - Huron was found not in compliance with the following requirement: S701.	S 000	On November 25, 2024 all caregivers were reeducated on the fall policy and procedure, revised fall check list, documentation in EMR and implementation of new vital signs sheets, one for head injury and one without. On Dec 6, 2024 To ensure a resident's needs are identified and addressed and to ensure caregivers are providing care within their scope of practice, caregivers were reeducated on the importance to complete vitals as recommended based on whether a fall happens with or without a head injury. Reeducation entailed reviewing the Change in Condition Policy, revised fall checklist and the two new post fall vital sheets, one with head injury or without head injury. Resident monitoring will be completed by staff per guidance from these documents and in conjuction with nursing discretion and delegation as appropriate. Audits on all fall charting will be done by DON or designee weekly for eight weeks then monthly for three months, then quarterly for six months. Post Fall evaluation will be done for all falls for three days, then weekly for one month, by DON or designee. Audit results will be presented at the facility's quarterly QAPI meetings by the DON or designee.	12/06/2024
S 701	44:70:08:01(1-6) Record Service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician assistant's, or nurse practitioner's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to ensure	S 701		

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

Stephanie Metzger RN, ED 12/9/24

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S 701	Continued From page 1	S 701		

sufficient documentation to support residents' individual needs had been identified and addressed for two of two sampled residents (1 and 2) who had fallen while residing in the facility. Findings include:

1. Interview on 11/19/24 at 10:15 a.m. with director of nursing (DON) B during the entrance conference revealed:
*The facility had started admitting residents after it opened in September 2024.
*There were eleven residents, one resided in the memory care unit (MCU) and ten resided in the main assisted living area.
*Information was requested including the following:
-A list of current residents that was to identify which residents had fallen since their admission.
-All incident and fall reports and investigations including reports to the South Dakota Department of Health (SD DOH).
-Policies on abuse and neglect, falls and fall follow-up, nursing services, and documentation.

Interview and record review on 11/19/24 at 11:20 a.m. with unlicensed medication aide (UMA) C and resident care aide D at the assisted living area's nurse station revealed:
*Both had worked there since the facility had opened.
*They were familiar with the residents who resided in the assisted living area and the MCU.
*The process for residents who had falls was discussed and included the following:
-If a resident had fallen the staff would not have moved them until the nurse had been notified.
-The staff would also get a set of vital signs on the resident right away.
-If the nurse was in the building then the nurse would come to assess the resident.

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S 701	Continued From page 2 -If the nurse was not in the building the staff would have called the nurse for direction. *There was a binder at the nurse station with a Fall Checklist and a Post Fall Vitals sheet they referred to. *The Fall Checklist listed seventeen areas to be initialed when completed with guidance and instructions. *The Post Fall Vitals sheet indicated vital signs and a pain score were to be done at 8:00 a.m., 1:00 p.m., and 8:00 p.m. on days 1, 2, and 3. *They would have followed the nurse's direction if anything else needed to be done. Interview and record review with DON B on 11/19/24 at 2:45 p.m. regarding resident falls revealed: *She provided the progress notes for each resident fall that had occurred since the facility had opened. -There were no other internal notes related to those falls. *The three progress notes included: -On 10/1/24 at 10:41 a.m. resident 1 had been found by staff sitting on the floor of her room in front of her lift chair which was in a high position. The resident had denied pain and no injuries were noted. -On 10/2/24 at 12:08 p.m. resident 1 had been found on the floor in the doorway of her room and her kitchen area. The resident denied pain and no injuries were noted. -On 11/7/24 at 9:40 a.m. resident 2 was found sitting on the floor. She complained of right knee pain and had a red area to her right lower outer knee but no other injuries. *Resident 2 currently resided in the MCU. *Resident 1 had been sent to the emergency room on 10/4/24, was admitted to the hospital on 10/5/24 for a brain bleed, and had not returned to	S 701		

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S 701	Continued From page 3 the facility. *No other residents had a fall since their admission. *Additional documentation for the above residents' falls was requested including the Fall Checklist and Post Fall Vitals sheets. Observation and interview on 11/19/24 at 2:50 p.m. with resident 2 in her room revealed: *UMA E was assisting the resident with a gait belt and to use her walker to get into her recliner. *The resident had difficulty responding to questions and following the directions of the UMA to sit down in the recliner. *When asked what her name was she smiled and did not answer. Interview on 11/19/24 at 3:10 p.m. with UMA E at the MCU nurse station revealed: *She had worked at the facility since it opened and worked in the MCU often. *Resident 2 was cognitively impaired and required assistance from the staff with her cares. *She had worked the day resident 2 had fallen a few weeks ago. *At the time of resident 2's fall UMA E had been at the nurse's station and heard a loud noise. *She went to the resident's room right away since it was close to the nurse's station and had found the resident sitting on the floor. *She called the nurse who came down to the MCU, assessed the resident, and helped get the resident off the floor. *For resident falls the staff would have let the nurse know of the fall. -If the nurse was in the building they would have come to assess the resident right away. -If the nurse was not in the building the staff would call and the nurse would have given the staff direction on what to do.	S 701		

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S 701	Continued From page 4 *After a resident fell they would follow the instructions on the Falls Checklist and Post Fall Vitals sheet. -The Post Fall Vitals sheet had them do vital signs for the resident three times a day for three days. *The staff would write the vital signs on the sheet and enter them into the resident's electronic medical record (EMR). 2. Review of resident 1's EMR revealed: *She was admitted on 9/30/24 from a skilled nursing facility. *Her diagnoses included Parkinson's disease, visual hallucinations, abnormal weight loss, idiopathic hypersomnia (excessive daytime sleepiness and difficulty waking from sleep), chronic fatigue, generalized anxiety disorder, and osteoporosis (disease that weakens bones). *Her 9/30/24 Brief Interview for Mental Status (BIMS) assessment score was six which indicated she had severe cognitive impairment. *Her 9/30/24 Morse Fall Evaluation indicated she was at high risk for falling. *Her 9/30/24 Level of Care/Functional Assessment - Assisted Living indicated she required: -Safety checks every two hours related to her cognitive impairment. -Assistance with decision making due to cognitive impairment. -Assistance with her activities of daily living. -Safety checks related to her risk of falls. *Her care plan was initiated on 10/2/24 and included a fall section with interventions of: -"Initiate safety checks on resident every 30-45 minutes when up in chair." -"Remind and show resident how to call for assistance with Carepredict [digital system developed for senior care]."	S 701		

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S 701	Continued From page 5 *There was no specific mention of her falls on 10/1/24 and 10/2/24 in her care plan. Review of resident 1's progress notes from her admission on 9/30/24 through 10/5/24 revealed: *On 9/30/24 there were several order notes for medications but there were no notes that indicated her arrival and admission to the facility or her health status at that time. *The first nursing note was on 10/1/24 at 10:41 a.m. related to the fall in her room that stated: -"Staff reports resident care predict alerted a fall. Staff went to room and found resident sitting on floor in front of her lift chair. Residents chair was in the high position. Resident smiling at staff, assessed by RN [registered nurse], no c/o [complaint of] pain or discomfort. Assisted to stand and back in chair with ext [extensive] assist of 2 and gait belt. No injuries noted. Vitals within normal limits. T 98.3 R 93 R 24 B/P 106/68. Daughter [name] notified. Dr. [name] notified." -There were no additional details to support investigation into the fall, if she had potentially hit her head, or if any change in her condition had occurred. *On 10/1/24 at 8:29 p.m. the nursing note stated: -"[Resident] is very sleepy again tonight. Staff have found her 3x [times] since 7pm leaned over the side of her chair. Once she told them she was looking for the donkey, next time was picking up the rocks and the 3rd time was going to unplug the heater. Resident kept eyes closed while talking. Up to bathroom with walker and gait belt, resident needed increased cueing to open her eyes when walking. Resident unable to wipe her buttocks from having BM [bowel movement]. Staff needed to assist, increased checks from every 2 hours to every 30-45 minutes tonight while in chair." -It was unclear if this was a change in her	S 701		

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S 701	Continued From page 6 condition from her admission on 9/30/24 or from the fall that occurred earlier that day. *On 10/2/24: -At 10:10 a.m. the nursing note stated: "[Resident] is very 'out of it today' asking 'where is the bus station, I'm late to the bus station' wording is not appropriate. Having to check on her at least every 10-15 minutes as she's getting up from recliner with footrest still up..." -At 12:08 p.m. the nursing note stated: "Called to resident's room by staff. Staff were going to get resident ready for lunch. When they opened the door they found [resident] sitting on the floor in the doorway of the room and kitchen. [Resident] had been in her recliner with the feet up. Remote for recliner was in reach on the arm rest. [Resident] had crawled out of her chair. [Resident] would not tell us what she was trying to do. Resident assessed by RN able to move all extremities per her usual. No c/o pain or discomfort. T 98.3 P 103 R 17 B/P 108/72. Up to stand with extensive assist of 2 and gait belt. Daughter and Dr. notified of fall." -There were no additional details to support investigation into the fall, if she had potentially hit her head, or if any change in her condition occurred. *On 10/3/24 at 11:00 a.m. a nursing note stated: -The resident was sitting in her chair with her feet up, had no signs of pain, was transferring with one staff person assistance to her wheelchair, and would not keep her eyes open to walk. -It also stated "Has no ill effect from fall yesterday. Post fall V/S [vital signs] has been within normal range for resident." *On 10/3/24 at 4:33 p.m. a note indicated the resident's daughter was there and was updated on the resident having hallucinations and increased need for help with care. The resident had a doctor's appointment scheduled for	S 701		

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S 701	Continued From page 7 10/4/24, the daughter would take her and would discuss the falls and her general decline. *On 10/4/24: -At 9:30 a.m. a nursing note indicated the resident was unable to feed herself and did not comprehend what she had to do. -At 10:40 a.m. the daughter arrived to take the resident to her doctor's appointment and was updated on the resident not being able to feed herself that morning. -At 11:54 a.m. the resident returned from the doctor's office where she had laboratory (lab) work done and a request for the facility staff to try to get a urine sample from the resident for a urinalysis test. -At 2:49 p.m. doctor's orders were received to discontinue a medication and recheck her lab work in one week. -At 3:02 p.m. the daughter was called and updated on the labs and orders. -At 5:18 p.m. the doctor's office called and indicated the resident's chest x-ray showed pneumonia. The doctor ordered two antibiotics and another medication to be started. A message was left for the resident's daughter to update her. -At 6:54 p.m. the staff called the nurse to report the resident was trying to walk all over the hallways, they were unable to redirect her, and staff notified the daughter to see if she would come visit. -At 6:58 p.m. the daughter called the nurse and wanted the resident to go to the emergency room (ER) by ambulance as she felt something else was going on. The ambulance was notified and the resident left the facility at 6:45 p.m. that evening. --The timeline of the resident leaving the facility did not correlate with the times of the nursing notes. *On 10/5/24 at 12:16 a.m. the facility staff was	S 701		

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S 701	Continued From page 8 notified by the hospital that the resident had a brain bleed and was being flown to a larger hospital. -There were no further notes after that time. Continued review of resident 1's EMR revealed: *There was no 10/1/24 Falls Checklist or Post Fall Vitals sheet found to support vital signs had been taken and follow up had occurred for the 10/1/24 fall. *The 10/2/24 Falls Checklist had six areas with staff initials and six areas with lines through them, but the following areas had been left blank: -"If vitals out of parameters OR resident hit their head OR if resident is on blood thinners, MANDATORY CALL to on call nurse at the time of the fall..." --Parameters for blood pressure, heart rate, oxygen level, temperature, and respirations were listed. -"If the resident has obvious signs of injury needing emergency attention, call 911 (ex. Resident is unconscious/not responsive, has obvious deformity of limbs, or severe bleeding." -"If resident is sent to ER/Dr. for evaluation, print the PCC [Point Click Care] Transfer/Discharge report and a copy of advanced directives/CPR status and send with them." -"Complete Post Fall Investigation Report in point click care." -"Put in nursing order for post fall vitals. Vitals 3x [times] a day. If head injury, every 4 hours, Nurse discretion." *The 10/2/24 Post Falls Vitals sheet had been complete for days 1, 2, and 3 except for the 6:00 p.m. section on day 3. *The 10/4/24 Office Clinic Note for her doctor's visit included: -The resident had a significant decline in her condition since admitting to the facility on 9/30/24.	S 701		

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S 701	Continued From page 9 -Her medications remained the same upon her admission from the previous facility. -Her neurological exam was "somnolent [drowsy], responds to questions." -The assessment and plan included suspected metabolic encephalopathy, worsening hallucinations, and falls risk. *The 10/4/24 CT Head Final Report included: -"Acute left subdural hematoma [blood pooling in the brain] overlying the left frontoparietal and temporal lobes [areas to the left front and side of the head]..." *Safety check documentation was not found. Review of the provider's SD DOH Required Healthcare Facility Event Reporting form for resident 1 revealed: *DOH was notified on 10/5/24. *The brief summary explanation included: -"Resident has been having increased confusion with hallucinations and continued decrease in ability with ADLs [activities of daily living] since admit on 9/30/2024. [Resident] has had two falls here at facility without injury on 10/1/24 and the other on 10/2/24. [Resident] had scheduled Dr. appt [appointment] today with [name] and was dx [diagnosed] with pneumonia. After supper [resident] became very restless with staff unable to redirect. Daughter [name] was called to help calm [resident]. [Daughter] requested [resident] to be seen in ER due to her continued confusion. [Resident] sent to ER via ambulance at 6:50 p.m. on 10/4/24. Received call from [hospital] ER that [resident] was being flown to [another city] due to a brain bleed. *The investigation conclusion included a lengthy summary that included details not found in the resident's EMR including: -"...Resident was assessed by a [an] RN for any injuries including head injuries after each fall and	S 701		

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S 701	Continued From page 10 none were noted. Vital signs were taken after each fall and done three times a day one-at [the] time of fall in the afternoon and after supper. Day two of post fall vitals they were only done at 8am as the post fall vitals were restarted due to second fall. All vitals were in normal range for resident from her admit vitals. Staff had been doing safety checks on resident every two hours since admission due to her increased fall risk. After her falls and with increased hallucinations staff were educated to increase the checks to every 30-45 minutes..." --In the above review of resident 1's EMR there was no documentation of her being assessed for a potential head injury, the 10/1/24 Falls checklist and Post Fall Vitals were not found, and the Safety Checks documentation was not available for review. Interview on 11/19/24 at 3:30 p.m. with DON B regarding resident 1 revealed: *She confirmed the documentation in the resident's EMR had not included all the details that were in the SD DOH report. *She felt she had assessed the resident for a potential head injury following both falls on 10/1/24 and 10/2/24 but had not included that in the notes. *She confirmed there was no nursing note addressing the resident's arrival and health condition at the time of her admission on 9/30/24 to support if the falls were a change in condition from her previous level. *The paper forms for the Falls Checklist and Post Fall Vitals from 10/1/24 had been done at the time but were not able to be located now. -At the time of the resident's falls the staff were not entering the vital signs into the EMR but they had started that process now.	S 701		

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S 701	Continued From page 11 3. Review of resident 2's EMR revealed: *She had admitted on 10/10/24 to the MCU. *Her diagnoses included dementia, anxiety, adult failure to thrive, and osteoporosis. *Her 10/10/24 BIMS assessment score was three which indicated she had severe cognitive impairment. *Her 10/10/24 Morse Fall Evaluation indicated she was at high risk for falling. *Her care plan was initiated on 10/11/24 and included a falls section with interventions of: -"Initiate safety checks on resident." --No frequency was specified. -"Initiate toileting and/or incontinence management." --No additional details were included. -"Staff will encourage the use of resident's device at all times when ambulating. With gait belt." *There was no specific mention of her fall on 11/7/24 in her care plan. Review of resident 2's progress notes from 11/7/24 through 11/19/24 revealed: *On 11/7/24 at 9:40 a.m. a nursing note included the RN being called to the room by the UMA. The resident was found sitting on the floor on her buttocks rubbing her right knee. She was assessed for injury and stated no when asked if she hit her head. There were no redness or bumps noted to her head. She had a red area noted to her right knee and was given medication for pain at that time. *On 11/7/24 at 2:05 p.m. a nursing note stated the resident was able to ambulate without pain or discomfort from the fall earlier. *On 11/10/24 at 9:00 p.m. a UMA note indicated the resident was very agitated and seemed upset. She asked the resident if she was in pain and the resident said yes and was holding her left knee. She was given an as needed pain medication but	S 701		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80607	A. BUILDING: _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - HURON	1714 OHIO NW HURON, SD 57350

(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 701	Continued From page 12 refused to drink water to swallow the pill for approximately three minutes. She did swallow the pill and laid down for the night. *On 11/11/24 at 1:55 p.m. a nursing note stated the resident has been up per usual with a gait belt, walker and assist of one staff person. The resident had no increase in pain or discomfort from fall on Thursday (11/7/24). -There was no documentation of a nursing assessment from 11/7/24 evening through until the above 11/11/24 note. Review of resident 2's November 2024 Medication Administration Record (MAR) revealed: *Her pain level was documented related to a scheduled arthritis pain relief medication that was given every morning and at bedtime. *Her pain level had been documented as a level zero most dates and times but had been documented as: --A level seven on 11/7/24 at bedtime. --A level two on 11/8/24 at bedtime. --A level one on 11/9/24 and 11/10/24 at bedtime and on 11/12/24 in the morning. *She had received an as needed narcotic pain medication after her 11/7/24 fall at the following times: -On 11/7/24 at 10:14 a.m. and at 7:09 p.m. -On 11/10/24 at 9:52 p.m. Interview on 11/19/24 at 3:30 p.m. with DON B regarding resident 2's fall follow up and documentation revealed: *There were no nursing assessment notes related to the fall other than on 11/7/24 and 11/11/24. *There should have been a note on 11/8/24, but she had been on leave that day. -There were two other nurses who worked there	S 701		

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S 701	Continued From page 13 in other roles that could have filled in for completion of the nursing assessment and documentation. *She typically only charted during the weekdays which explained why there were no nursing notes on 11/9/24 and 11/10/24 since they were on the weekend. *She confirmed the resident's MAR showed the resident had rated her pain differently in the few days after the fall. That had not been addressed in the nurse notes. *There was no indication the resident's knee was reassessed by the nurse related to the red area noted on 11/7/24. 4. Interview on 11/19/24 at 4:15 p.m. with DON B and administrator A revealed: *They confirmed the only falls that had occurred since the facility had opened were for residents 1 and 2 as noted above. *Documentation in the residents' EMRs should have supported what occurred at the time of the fall and in follow up to the fall including assessments of the resident's condition. *The facility had policies and the Falls Checklist and Post Fall Vitals sheets to follow. -Those had not clearly defined processes for potential head injuries or how often or for how long nursing assessments should have occurred related to falls. Review of the provider's 8/1/23 Change of Condition policy revealed: *"...Observations that may indicate a change in condition may include change in mental or physical function, abnormal vital signs, increased or new behaviors, changes in appetite or pain levels, for example." *Documentation in the medical record should have included:	S 701		

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S 701	Continued From page 14 -Date and time of condition change. -Resident symptoms and interventions. -Steps taken to ensure resident safety. -Vital signs. -Persons notified of condition change and directions, including notification date/time of the nurse, family/power of attorney/guardian, and/or provider. *The nurse should have conducted a follow-up evaluation the next working day and document in the medical record. *"3. A licensed nurse will continue to monitor all changes in condition until the change in condition has stabilized or the resident is transferred or discharged from the assisted living location." *"4. The nurse will complete evaluations and update the service plan as needed for significant changes in condition." Review of the provider's 8/1/23 Fall Response policy revealed: *"3. The nurse or the person who found/witnessed the fall will initiate the incident report and complete the Post Fall Investigation report in PointClickCare [EMR system]." *"d. Complete Fall Checklist and return to DON/designee per facility policy." *"a. If resident has signs of head injury or other significant pain/injury the nurse or delegated staff member should inform the resident/responsible part of risks and potential complications, with option to have resident evaluated by a provider (physician or nurse practitioner/physician assistant) in the Emergency Room or Urgent care/clinic, as available depending on time/location." -There was no mention of what to monitor, how often to monitor, or what to document for a potential head injury or other injuries if the resident was not sent for evaluation.	S 701		

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S 701	Continued From page 15 *"9. Nursing assessment documented in progress notes. If nurse is not present at time of fall, follow up documentation by a nurse should be charted the next working day after the fall."	S 701		

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12/9/24