STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80090	A. BUILDING: _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - SPEARFISH	6800 SAINT ONGE ROAD SPEARFISH, SD 57783

(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 An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/6/25 through 10/8/25. Peaceful Pines Senior Living-Spearfish was found not in compliance with the following requirements: S120, S130, S165, S296, S337, S450, S468, S485, S506, S690, and S835. 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 from 10/6/25 through 10/8/25. Areas surveyed included potential resident neglect and abuse related to a resident fall, and potential resident neglect and nursing services related to resident evaluations, catheter care, and activities of daily living (ADL). Peaceful Pines Senior Living-Spearfish was found in compliance.	S 000		
S 120	44:70:02:08 Linen The supply of bed linens must equal two times the licensed capacity of the facility. The facility shall develop and implement written procedures for the storage and handling of soiled and clean linens. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two sets of bed linens and a supply of towels to equal three times the facility's licensed capacity were available for use by all 43 residents who currently resided in that facility, according to the provider's	S 120	On 10/28/2025, Executive Director purchased the following bed linen sets to ensure there was slightly more than two times the total number of our current occupancy: Twin XL - 30 sets Full/Double - 40 sets Queen - 70 sets Total – 140 bed linen sets	11/21/2025

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S 120	Continued From page 1 policy. Findings include: 1. Observation and interview on 10/7/25 at 1:30 p.m. with housekeeper F in the laundry room revealed no extra linens were available for resident's use. She stated all residents were expected to provide two sets of their own linens. There was one drawer about 24 inches wide and four inches deep with folded towels inside of it. A piece of paper on top of those towels indicated they were for guest use. Housekeeper F stated that meant those towels were available to be used by a resident's family member or visitors. Interview on 10/8/25 at 3:00 p.m. with executive director A revealed she had purchased 12 flat sheets after she was hired in April 2025 because there was no supply of extra linens at that time. She was aware of the above quantity of available towels. She knew the expected amount of linens and towels that were to be available for the residents' use. She agreed that expectation was not met. Review of the provider's updated 8/1/22 Laundry/Linen policy revealed that the facility will "supply bed linens to those residents that do not provide their own, bed linen supplies shall equal two times the licensed capacity; supply towels to those residents that do not provide their own, towels shall equal three times the licensed capacity.	S 120	Upon receipt of those items, they will be laundered and maintained for resident distribution and use in the Assisted Living and Memory Care units. These bed linens will be stored in clear totes, labeled by sheet size, and stored in the Assisted Living laundry room. The deadline for completion is November 21, 2025. The total licensed bed number is 61. Therefore, to ensure ongoing compliance with the total amount of linens available, the Maintenance Director, or designee, will ensure inventory is tracked by his housekeeping staff. Upon any items included within the linen supply reaching a total count of less than 140 sets, the Maintenance Director or Executive Director will be notified. The Maintenance Director, or designee, will then be responsible for ensuring the necessary items are ordered to maintain consistent supply numbers. The inventory log will be reviewed by the Maintenance Director twice weekly for 8 weeks, followed by weekly for 4 weeks, and then twice per month and ongoing. As of 10/2892025, our current policy referencing the stocking/storage of bed lines to meet the requirements of 44:70:02:08 Linen; has been revised and the reference to the stocking and storage of towels will be removed. Inventory logs will be shared at quarterly QAPI meetings for discussion/recommendation.	
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control.	S 130	Director of Nursing performed direct and immediate hands-on education to staff member "UMA G" on 10/06/25 after it was reported to Director of Nursing from Surveyor.	11/21/2025

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S 130	Continued From page 2 Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, observation, interview, and policy review, the provider failed to ensure infection control practices were followed by one of one unlicensed medication aide (UMA) (G) during one of one sampled resident's (7) observed skin treatment. Findings include: 1. Review of resident 7's care record revealed a 7/24/25 physician's order for Betadine (a topical antiseptic solution) to be applied to the resident's left toes. There was a 4/1/25 physician's order for Lidocaine (a local anesthetic) to be applied topically to those same toes after the Betadine application. 2. Observation and interview on 10/6/25 at 11:45 a.m. with UMA G in resident 7's room revealed the resident was seated in his recliner. After UMA G applied clean gloves, she released the velcro on the boot that was on the resident's left foot, rolled up his pant leg, and rolled down a leg sleeve that covered gauze that was wrapped around his left foot. She then unwrapped the left foot gauze covering and placed it on the carpeted floor.	S 130	A review of the onboarding requirements and competency skills for UMA's working at the building was completed by Business Office Manager and Executive Director on 10/21/2025. It was confirmed that competencies for proper infection control are included within new hire training. During all-staff meeting(s) scheduled for November 13, 2025, re-education and training will be conducted by Director of Nursing to all staff on proper infection control processes/practices, as well as proper glove use. DON (or designated RN) will re-educate UMA G on the UMA Med-Aide check list – deadline for completion of this re-education is November 21, 2025. Newly signed checklist will be placed in employee education file. Education audit was conducted by Business Office Manager on 10/21/2025 and all newly hired staff who had not yet completed the required training within the first 30-days of hire were identified. Supervisors of these employees were notified and deadline set for staff to complete the training (which includes infection control and glove use) no later than November 1, 2025. Business Office Manager will track the progress of education completion and will communicate to supervisors the status of each staff member who has not yet completed the new-hire training. Should any employees remain non-compliant, Executive Director will individually discuss with the appropriate employees and disciplinary action will be executed, as necessary.	

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S 130	Continued From page 3 There was a pad with some red-colored drainage on it, between the resident's great toe and the toe next to it. The resident's toes were a deep red color with some blackened areas. With those same gloved hands, UMA G squirted Betadine directly onto those same gloved hands then rubbed the Betadine onto the resident's toes. She stated, "I don't have a swab [to use to apply the Betadine directly onto the resident's toes]". UMA G then squeezed Lidocaine cream directly onto those same gloved hands and applied that cream to the resident's toes. UMA G then removed her gloves and did not wash her hands. With her bare hands, she picked up the gauze off of the carpeted floor and placed it back onto the resident's left foot. UMA G exited resident 7's room, and stated she had worked at the facility for about two weeks. In addition to on-line training, UMA G had shadowed another UMA for about a week or so before she began working on her own. UMA G stated had not observed another UMA or licensed nurse complete resident 7's skin treatment before she worked on her own at the facility, but she had completed skin treatments similar to resident 7's at other healthcare facilities where she had worked. UMA G agreed she had missed opportunities for glove removal, hand washing, and applying clean gloves moving between preparing resident 7 for the skin treatment and performing the skin treatment. She also agreed that topical solutions and creams should have been applied using a packaged swab and not with her unclean gloved	S 130	To ensure ongoing compliance with proper infection control processes, DON or designee when working in the community will shadow infection control specific cares being completed by at least one scheduled UMA: For applicable residents 2 weeks (one time a day Mon-Friday), then 4 weeks (two times a week), then 4 weeks (one time a week) 12 weeks (one time every other week) Provided the process is witnessed to be completed accurately, infection control and proper glove use will be an agenda item once a quarter during staff meetings until the end of calendar year 2026. The results of these audits will be shared during the community's quarterly QAPI meetings, with the ED overseeing the process to ensure audits are completed and shared at QAPI meetings. The next care staff meeting to be held on November 13, 2025, where the DON will address infection control and proper glove use. Dressing changes completed by a Nurse or Designee will be managed based on the physician's orders. Director of Nursing or designee will train those staff members eligible to perform basic wound care and dressing changes upon hire, annually, and upon receipt of new or changed physician's orders to ensure competency Upon hire and annually the Director of Nursing or designee will perform skills competency training for all current and eligible care staff based on their title and scope of practice. A care staff skills fair to be held at the community in the month of December, 2025 for all current care staff to cover skills competency training. .	

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S 130	Continued From page 4	S 130		

hands. UMA G did not know if resident 7's gauze foot wrap was to be re-used after his skin treatment, and she did not ask a licensed nursing staff for clarification.

3. Interview on 10/6/25 at 3:30 p.m. with director of nursing (DON) B regarding the above skin treatment observation revealed resident 7's foot was to be monitored, assessed, and treated three times weekly by a home health nurse. The resident had peripheral vascular disease (a narrowing of the arteries resulting in reduced blood flow) which she thought had contributed to his chronic toe wounds.

DON B confirmed UMA G should have removed her gloves, performed hand washing, and applied clean gloves after removing the gauze wrap and before applying the Betadine with a clean swab to resident 7's foot. The unclean gauze wrap that was placed on the floor should not have been re-applied to resident 7's foot.

A Skin Treatment policy was requested on 10/7/25 at 12:50 p.m. from director of operations N. She indicated there was no policy for that, only an Application of Ace Bandage skills checklist which did not include hand hygiene and glove use.

Review of the provider's revised 3/21/22 Hand Hygiene policy revealed employees were expected to wash their hands:
*"Before and after assisting residents or staff with any contact with bodily fluids, blood, mucous membranes, non-intact skin, or any other contaminated surfaces."
" Touching [the] floor, wheelchairs, exercise equipment, or any contaminated objects."

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S 130	Continued From page 5 Review of the provider's revised 9/1/23 PPE (personal protective equipment): Glove Use policy revealed: "7. Change gloves during care if your hands will move from a contaminated body site to a clean body site."	S 130		
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two sampled residents (10 and 11) in the memory care unit (MCU) did not have unrestricted access to hot food items in the MCU. Findings include: 1. Observation on 10/6/25 at 4:50 p.m. revealed the MCU kitchenette was a walk-through galley style kitchenette. Director of culinary services (DCS) C removed the food and beverages for the evening meal service from inside the insulated food cart, and placed them on the kitchenette countertop. That countertop faced a living room area. DCS C left the MCU with those items unattended.	S 165	Executive Director met with all supervisors, to include Dining Services Director, on 10/7/2025 to educate on and iterate that food/drink carts delivered to Memory Care can never be left unattended. The identified process for this is that staff delivering the meal carts must personally hand-off to another staff member if they are unable to provide the service themselves. Additionally, all food carts delivered to Memory Care, when not in use, must be placed in the pantry (located behind the Memory Care kitchenette). Both PRN RN's were notified of the same by the Executive Director on 10/7/25 and 10/8/2025. During dining staff meeting held by DDS and ED on 10/27/2025, all dining staff were notified of the same. On 10/27/2025, during meeting with DON, Maintenance Director and Dining Services Director, the ED implemented the following safeguard (effective 10/28/2025) for hot beverages located/used in Memory Care:	10/28/2025

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S 165	Continued From page 6 Resident 10 entered the unattended kitchenette and poured herself coffee from the carafe on the kitchenette countertop. Resident 11 entered the unattended kitchenette a few minutes later and lifted the metal lid of one of the metal food containers on the countertop. Resident 11 then poured herself coffee from the same coffee carafe above. The above metal container was observed as filled with steaming hot soup. The outside of that container was hot to the touch. Interview on 10/6/25 at 5:00 p.m. with registered nurse (RN) D revealed the unrestricted access that MCU residents had to the kitchenette had been identified as a safety concern for "over a year". Staff had asked for a modification to the kitchenette galley to prevent the unrestricted access of residents to that area. Review of the provider's 10/6/25 food temperature log revealed the above soup was 192 degrees Fahrenheit (F) before it was transported to the MCU kitchenette for serving to the residents. A temperature greater than 160 degrees F posed a burn risk. Interview on 10/7/25 at 3:40 p.m. with executive director (ED) A revealed food and beverages were not to be left on the MCU kitchenette countertop unattended. She expected that the kitchen staff person who delivered the meal to the kitchenette area to stay with the prepared foods and to serve that meal. If that was not possible, the meal should remain in the secured insulated food cart until an MCU staff person was able to serve that meal. ED A thought that DCS C was aware of those expectations.	S 165	All carafe's containing hot liquids will only be handled by staff and will only be distributed to residents by staff. When not in use by staff, these carafe's will be stored in the upper cabinet of the kitchenette, beside the coffee cups. This cabinet is secured with a safety latch to ensure that residents are unable to access. The safety latch was installed on 10/27/2025. ED notified all staff of the requirement to personally hand-off service carts to staff, to store in pantry when not in use, and how/where to store carafe's containing hot liquids via posted written notice in Memory Care kitchenette, written notice posted on the insulated Memory Care food cart, written notice posted in the kitchen, and through notification in ECP software to all staff on 10/28/2025. Director of Culinary Services will spearhead the continued compliance efforts. DSD will personally observe the meal delivery process to Memory Care (when on shift or will designate a culinary staff member) daily for 4 weeks and ensure the complete process is followed, as directed. With successful compliance, DSD will then reduce his observations of this process to 3 times weekly for 2 weeks, followed by once weekly for 2 weeks and then weekly thereafter. The Executive Director will choose randomly selected dates within the audit process and thereafter to personally observe this process and ensure compliance and oversight by DSD. Audit/logs and/or observation notes will be shared at quarterly QAPI meetings for discussion/recommendation.	

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S 165	Continued From page 7 Review of the provider's updated 8/5/22 Safety and Security policy revealed "The facility is equipped, maintained, and operated to avoid injury or danger to the residents, staff or visitors. Employees participate in protecting themselves, other staff members, residents, family members, and visitors."	S 165		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from	S 296	A review of all active employee training transcripts was reviewed by Executive Director and Business Office Manager on 10/21/2025. On October 22, 2025, BOM and ED ensured that the necessary training was assigned to any employee found to be non-compliant with annual training, and initial/onboarding online education. Employee H was assigned the required annual training on October 22, 2025 with a deadline for completion of November 21, 2025. Assigned training includes fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, resident rights, confidentiality, incidents and diseases subject to mandatory reporting and the facility's report mechanism, nutritional risks and hydration. Each applicable supervisor was notified via email from the Business Office Manager (cc ED) the employees that were identified as not yet completing the required new-hire training within the first 30-days of employment. These employees were given a deadline to complete their new-hire training by November 1, 2025.	11/21/2025

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S 296	Continued From page 8 the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel file review, interview, and policy review, the provider failed to ensure the required annual training was completed for one of one sampled employee (H). Findings included: 1. Review of employee H's personnel file revealed she was hired on 7/23/24 as a registered nurse (RN). She had not completed the required annual training for the topics of fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, resident rights, confidentiality, incidents and diseases subject to mandatory reporting and the facility's report mechanism, nutritional risks and hydration, and education based on the residents identified care needs. Interview on 10/8/25 at 10:55 a.m. with director of nursing (DON) B revealed employee H worked PRN (as needed) and was on call for one shift a month. DON B agreed RN H did not complete the annual required training. DON B stated she was informed administration was responsible for assigning the annual required trainings to each staff member's online education transcript for them to be completed. Review of the provider's 7/7/2022 Personnel	S 296	To ensure ongoing compliance with assignment and completion of annual training, Business Office Manager will monitor/audit education transcripts weekly and will notify the appropriate supervisor via email (cc the ED) an update of all staff with incomplete education and will remind the supervisor of the deadline date for completion. ED notified all supervisory staff on 10/21/2025 that all newly hired staff will not be scheduled to work in their respective departments until all of their online education requirements are completed. This will ensure that all staff complete the required education within the first 30-days of hire. Audit/logs and/or observation notes will be shared at quarterly QAPI meetings for discussion/recommendation.	

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S 296	Continued From page 9 training policy revealed: "The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. *Fire prevention and response *Emergency procedures and preparedness *Infection control and prevention *Accident prevention and safety procedures *Resident rights *Confidentiality *Incidents and disease subject to mandatory reporting and the facility's reporting mechanisms *Nutritional risks and hydration *Abuse, neglect, and misappropriation of resident property and funds *Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors *Any additional healthcare employee education necessary based on the individualized resident care needs provided by the healthcare employees to the residents who are accepted and retained in the facility"	S 296		
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 observation, interview, record review, and policy review, the provider failed to ensure:	S 337	On October 8, 2025, DON contacted PCP for Resident 1 and Resident 1's Diet orders have been reviewed and clarified with PCP. Resident 1's order was clarified to be regular diet with thin liquids. Moving forward, if/when a patient discharges from hospice services, a new evaluation and updated orders will be started and/or continued. On October 8, 2025, DON contacted PCP for Resident 1's oxygen orders to be clarified/corrected. PCP updated order oxygen order and changed to PRN due to resident not needing but preferring to have.	11/13/2025

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S 337	Continued From page 10 *One of one sampled resident's (1) diet order had been updated to reflect her current diet needs. *One of one sampled resident's (1) oxygen order had been updated to reflect her current supplemental oxygen needs. *One of one observed unlicensed medication aide (UMA) (E) had followed a physician's order for the administration of one of one sampled resident's (2) vitamin supplement. *One of one observed UMA (E) had followed the manufacturer's instructions for the use of an inhaler that was self-administered by one of one sampled resident (3). Findings include: 1. Review of resident 1's care record revealed an 11/11/24 physician's order for the resident to receive a regular texture diet and nectar consistency fluids. That order coincided with the resident having been placed on hospice services. On 12/24/24, hospice services were discontinued. A 6/7/25 dietician's annual assessment indicated resident 1 was on a regular diet with nectar thick liquid consistency and the resident had "no signs or symptoms of chewing or swallowing related issues." 2. Observation and interview on 10/6/25 at 12:35 p.m. with resident 1 in her room revealed she was seated in her recliner. A cup of coffee and a water-filled cup were beside her on an end table. She stated nothing was added to the fluids she drank to thicken them. She had no concerns regarding her ability to safely swallow fluids. 3. Interview on 10/6/25 at 3:00 p.m. with director of nursing (DON) B revealed resident 1's current diet order for nectar thick liquids was initiated at	S 337	To ensure ongoing compliance with correct medication order, beginning 10/29/2025, the Director of Nursing or Designee will audit each current resident's diet and medication orders every two weeks for six months, through April 30, 2026, to ensure active and discontinued physician orders are accurate. The results of these audits will be shared during the community's quarterly QAPI meetings, with the Administrator overseeing the process to ensure audits are completed and shared at QAPI meetings. DON will provide re-education to all active Medication Aides on the 5 rights of medication administration and the importance during all-staff meeting scheduled for November 13, 2025. DON provided immediate face-to-face education with UMA E on inhaler administration and sublingual administration and the importance of route and aftercare. Proper inhaler administration will be addressed/discussed during all-staff meeting scheduled for November 13, 2025. To ensure ongoing compliance with correct medication administration processes, DON or designee will meet with every active UMA staff member employed at the community and re-train them on proper inhaler administration and sublingual administration using the Inhaler Administration Skills Checklist and Sublingual Medication Administration Skills Checklist to ensure competency by November 13, 2025. Once all active UMA staff have completed the Inhaler and Sublingual Skills Checklist with Director of Nursing or Designee, the Director of Nursing or Designee will complete two times a week audits for 8 weeks to observe UMAs performing proper inhaler use and sublingual administration.	

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S 337	Continued From page 11 the time she was placed on hospice services. Nursing staff had faxed a communication to the resident's medical provider at that time to clarify that order because the resident was not experiencing swallowing or chewing issues that would have warranted the need for that diet modification. That fax was not responded to and no one had followed up with the medical provider to clarify that diet order. 4. Observation on 10/7/25 at 10:00 a.m. of the wall near the service window in the kitchen revealed a list of resident names and their specialized dietary requirements was posted. Next to resident 1's name were the words "nectar thick" liquids. 5. Interview on 10/8/25 at 1:15 p.m. with cook I and culinary aide L regarding resident 1's dietary information posted by the service window revealed any liquids provided by the kitchen for resident 1 were not altered. They were not aware if resident 1's fluids were to be thickened.. They did not think the nursing staff had told them the resident's fluids required thickening and they did not ask the nursing staff if the resident's fluids should have been thickened. 6. Observation and interview on 10/6/25 at 12:35 p.m. with resident 1 in her room revealed she was seated in her recliner and was not wearing oxygen. There was a portable oxygen concentrator and an oxygen cylinder in her room. Resident 1 stated she had not used either of those items in some time. She preferred that the concentrator and cylinder remain in her room "just in case" she needed them. 7. Review of resident 1's care record revealed orders on 11/15/24, to receive two liters of oxygen	S 337	Provided the process witnessed to be completed accurately after 8 weeks, the Director of Nursing or Designee will complete audits once a week and observe UMAs through April 30, 2026. Additionally, all medication skills competencies for UMAs will be conducted in December 2025 by Director of Nursing or designee.	

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S 337	Continued From page 12 via nasal cannula as needed (PRN) for oxygen saturation levels of less than 90% and on 11/25/24, to receive two liters of oxygen via nasal cannula at bedtime. Progress notes as recently as 9/24/25 had indicated "Res [resident] no longer uses O2 [oxygen] at bedtime." Review of resident 1's August 2025 through October 2025 daily documented oxygen saturation checks on room air (without the use of supplemental oxygen) revealed her daytime oxygen saturation levels were greater than 90%. There was no documented night time oxygen saturation checks taken when the resident was scheduled to have been using oxygen. 8. Interview on 10/7/25 at 8:45 a.m. with DON B regarding resident 1's oxygen orders revealed the resident was no longer using as needed or scheduled oxygen, but she preferred to have her oxygen equipment stored in her room. DON B agreed there should have been documentation to support what resident 1's night time oxygen saturation levels were when she had not worn oxygen. That documentation should have been provided to the resident's medical provider to have made an informed decision regarding the resident's need for the night time oxygen use order. A Physician's Order Clarification policy and/or a Following A Physician's Order policy was requested from director of operations N on 10/8/25 at 8:00 a.m. Operations director N stated the provider had no such policies. The provider's revised 8/1/23 Change of Condition policy was provided and revealed "2.	S 337		

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S 337	Continued From page 13 Licensed or registered nurse will evaluate all residents with condition changes and ensure their needs can be met in assisted living." Documentation in the resident's EMR was expected to include the person notified, including the resident's medical provider, of the change in condition and any directives they may have provided. 9. Observation on 10/7/25 at 8:10 a.m. of UMA E revealed she was preparing resident 2's morning medications for administration. One of those medications was a vitamin B-12 tablet (a vitamin the body uses to help with red blood cell formation and anemia prevention). Instructions on the vitamin B-12 medication card indicated that one tablet was to be administered sublingually (placing the tablet under the tongue for faster absorption). UMA E placed the vitamin B-12 tablet along with all of resident 2's other scheduled morning medications into a medication cup. That medication cup and a glass of water were taken into resident 2's room. UMA E had resident 2 swallow all of her medications from that medication cup, including the vitamin B-12 tablet. Interview on 10/7/25 at 8:15 a.m. with UMA E and review of resident 2's vitamin B-12 medication card revealed she had not followed the instructions for administering the resident's vitamin B-12 tablet. UMA E stated that she had not noticed that the vitamin B-12 tablet was ordered to have been administered sublingually. That tablet should have been separated from the resident's other morning medications to ensure it had not been swallowed whole and was administered according to the directions on the medication card.	S 337		

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10. Observation on 10/7/25 at 8:20 a.m. of UMA E revealed she was preparing resident 3's morning medications for administration. One of those medications was a Trelegy inhaler. After entering resident 3's room, UMA E administered the resident's oral medications then handed the resident her inhaler. After resident 3 self-administered her inhaler, she drank from a nearby water bottle.

Interview on 10/7/25 at 8:25 a.m. with UMA E regarding the above inhaler administration revealed she had not known that resident 3 should have swished then spit out and not swallowed the water she had in her mouth after she had used her inhaler.

11. Interview on 10/7/25 at 8:45 a.m. with director of nursing (DON) B regarding the above observations revealed UMA E had not administered resident 2's vitamin B-12 tablet according to the medication card instructions. Resident 3's inhaler was not self-administered according to the facility's policy regarding inhaler administration.

Review of the provider's undated Skills Checklist for sublingual medication administration revealed "7. For oral tablet, place [the] pill underneath [the] resident's tongue and allow to dissolve."

Review of the provider's undated Skills Checklist for inhaler administration revealed "15. For steroid inhalers, provide [the] resident with a cup of water and instruct [the resident] to rinse mouth and spit water back into [the] cup."

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S 450	Continued From page 15	S 450		
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, job description review, and policy review, the provider failed to follow safe and sanitary food service practices related to: *Food storage and the dating of packaged food in the assisted living center (ALC) kitchenette, the walk-in freezer, the walk-in cooler, the refrigerator, and dry food storage area. *Maintaining the kitchenette and kitchen equipment, including an ice and water dispenser, the microwave and a food processor, in a clean and sanitary manner. *Maintaining the kitchen storage areas, including metal countertops and shelves, in a clean and sanitary manner. *Hand hygiene and net beard use by one of one director of culinary services (DCS) (C) during the preparation of one of one observed meal service. *Temperature probe cleaning by one of one DCS (C) during the preparation of one of one observed meal service. *The sanitizer solution in the three-compartment sink in the kitchen where residents' meals were prepared and served maintained the minimum required parts per million (PPM) level for sanitizing. *Glove use by one of one registered nurse (RN) (D) during one of one observed meal service.	S 450	10/27/2025, ED utilized the SD DOH website and downloaded the Food Service Manager Self-Inspection Checklist for DSD to use for auditing/QC/Education/Training purposes and to ensure ongoing compliance with respect to kitchen operations, to include: equipment, food preparation, handling and service, cleanliness, sanitation and employee appearance. DSD will implement the use of this checklist on a weekly basis beginning 10/29/2025 and will audit/monitor, document and will provide/initiate immediate corrective action at the time of inspection for any findings out of compliance. Effective 10/29/2025, DSD will bring the completed inspection checklist to the ED for review. ED will review the completed checklist, and each week will address any training/education/compliance needs identified on the checklist for kitchen staff with the DSD. ED will co-sign and date the form. In addition to reviewing the checklist, the ED will observe the kitchen to verify the accuracy of the checklist and to confirm that any shortcomings noted on the checklist have been addressed. The Self-Inspection Checklist used on a weekly basis by the DSD will audit/monitor, document, and provide corrective action at the time of inspection as needed for the following: • Personal Dress and Hygiene – to include staff use of hair/beard nets, hand washing and proper glove use, eating/drinking in designated areas only. • Food Storage and Dry Storage – proper temperature checks, supplies are stored 6-8 inches off of the floor, all food is labeled with name and delivery date (to include items stored in the dining room, such as salt/pepper, coffee creamer, etc.), FIFO method is practiced, no bulging or leaking canned goods, all food (fresh/frozen/dry storage) is protected from contamination, all surfaces and floors are clean, chemical s are stored appropriately.	11/10/2025

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S 450	Continued From page 16 Findings include: 1. Observation on 10/6/25 at 10:00 a.m. of the ALC kitchenette revealed: *Inside the lower cabinets beneath the handwashing sink were two uncapped and unlabeled squeeze bottles. It appeared that salt and pepper were stored inside them. *There was a 1.5 liter bottle of salted caramel and chocolate creamer dispenser. There were instructions on the dispenser's label that read: "Write date product was opened with permanent marker, for best quality, use within 30 days." The blank space on the label for that information to be written on was blank. *There was lime build-up on the grates of the water and ice cube dispensing machine. Lime build-up was also present on the backsplash of the machine and inside and around the clear plastic ice dispensing chute. 2. Continued observation between 10:10 a.m. and 11:00 a.m. in the kitchen revealed: *In the walk-in freezer there was: -A metal pan. The foil on one corner of the pan had been folded over to expose some type of cooked meat. -An unsecured lid on a five-pound sour cream container that exposed orange-colored contents inside that container that was not sour cream. -Five bowls of uncovered ice cream. -Four bags of opened and unlabeled French fries. -A metal pan with two, white-colored, unmarked bags inside it. Yellowish colored contents from one or both of those bags had leaked into the pan. The two bags were frozen together and frozen to the bottom of the pan. *In the walk-in cooler there was: -A plastic tub that contained produce. Inside of	S 450	. Large Equipment – All pieces of equipment are clean to sight and touch, equipment on serving lines, storage shelves, cabinets, ovens, ranges, fryers and steam equipment will be inspected. Exhaust hood and filters will be inspected. The Maintenance Director has the cleaning of the hood and filters tracked and monitors through the TELS system and will continue to schedule the cleaning of the hood and filter •Refrigerator, Freezer – Thermometers are easy to find and accurate, temperature is accurate for piece of equipment, food is stored 6 inches off of the floor in walk-ins, proper procedures have been practiced, all food is properly wrapped, labeled and dated, FIFO method is practiced. •Food Handling – Frozen food is thawed properly, food is not allowed in the temperature danger zone for more than 4 hours, food tasting proper method is used, food is not allowed to become cross-contaminated, food is handled with utensils, clean gloved hands or clean hands, utensils are handled to avoid touching parts that will be direct contact with food, reusable towels are used appropriately. •Utensils and Small Equipment – all small equipment and utensils, including cutting boards, are sanitized between uses, small equipment and utensils are air dried, work surfaces are clean to sign and touch, work surfaces are washed and sanitized between uses. Thermometers are washed and sanitized between each use, can opener is clean to sight/touch, drawers and racks are clean, inside and outside of microwave is clean. •Hot Holding – Unit (steam table, container) is clean, food is heating to 165 degrees before placed in hot holding, temperature of food being held is above 140 degrees, food is protected from contamination. •Cleaning and Sanitizing – 3-compartment sink is used, is set up correctly, test kits are available and used, water temperatures are accurate, and sanitized water is tested and measures the proper dilution.	

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S 450	Continued From page 17 that tub there was a mesh bag with three oranges inside it. Two of those three oranges were moldy. Other produce inside that same tub included a cantaloupe and lemons. Additional produce was too discolored and moldy to identify. -Inside a second plastic tub were five heads of cabbage with black colored mold on them. The bottom of the tub was also blackened with mold. *Inside of the refrigerator two of three cans of whipped topping and one plastic bottle of caramel topping were uncapped. *Beside the proofing/holding unit was a metal countertop. Underneath that countertop were shelves. There was a rack on the shelf that held cutting boards. The area under those cutting boards had hard water stains on it. *The exterior and interior doors of the microwave were covered with smears and smudges. The entire inside of the microwave was covered with scattered food debris. *On the shelves in the dry food storage area there was: -One large cardboard box and one large plastic tub both filled with baking potatoes. The potatoes in the plastic tub were shriveled, dark in color, and had small clusters of sprouts growing out of them about two to three inches high. The potatoes in the cardboard box were less shriveled, dark in color, and had individual sprouts growing out of them less than two inches high. -A large, opened sack of seasoned bread crumbs. -A bag that contained seven hot dog buns. Mold was seen on one of the buns inside that bag. The date marked on the bag was 6/10/25. -Twenty-five liter plastic buckets of powdered sugar, regular sugar, rice, and flour with	S 450	.Heat sanitizing (dish machine) is in use and if so, the utensils are allowed to remain immersed in 170-degree water for 30 seconds, the water is clean and free of grease or food particles, the utensils are allowed to dry, wiping cloths are stored in sanitizing solution while in use. •Garbage Storage and Disposal – Kitchen garbage cans are clean, garbage cans are emptied as necessary, boxes and containers are removed from site, area around dumpster is kept clean, dumpster is closed. On 10/8/2025 the DSD called the Hillyard representative to come on-site to inspect the operation of the 3-compartment sink. Upon inspection the filter for the sanitizer dispenser was found to be plugged, this was replaced and 3-compartment sink began testing at the appropriate amount of dilution of sanitizer. On 11/3/2025, ED notified Hillyard representative that (effective immediately) during his monthly inventory/walk-through, he must add checking/maintenance of both the filter and the lines for the 3- compartment sink to ensure proper operation/function – and will change the filter as needed. 10/28/2025, the ED provided the DSD with the following checklists (taken from Dining RD Guideline and Procedure Manual): •Dining Services Opening and Closing Checklists (which includes cleaning procedures/tasks) •Monthly Cleaning Schedule DSD will implement the use of the checklists on 11/3/2025 and will educate his staff on their use. DSD will ensure two copies of the opening and closing checklists are available to staff and staff will be required to complete each shift and will submit to the DSD for his review on a daily basis. To confirm ongoing compliance that checklists are being utilized as directed and intended, the	

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S 450	Continued From page 18 unsecured lids. There was another, unmarked bucket without a lid that appeared to have flour in it. 3. Interview on 10/6/25 at 11:45 a.m. with executive director (ED) A and director of culinary services (DCS) C in the kitchen revealed they confirmed the above findings. DCS C stated, "I take full responsibility" for failing to maintain safe and sanitary conditions in the kitchenette and the kitchen. He indicated staffing challenges had been a barrier to him being able to effectively oversee kitchen operations. 4. Observation and interview on 10/7/25 at 10:10 a.m. with DCS C in the kitchen revealed the above produce had been removed from the walk-in cooler. One of the above two boxes of potatoes had been removed. DCS C had thought the second box of potatoes remained edible. He picked up one of the potatoes from that box, pierced the potato skin with his thumbnail to reveal a green tinge, a potential toxin. On a metal countertop across from the dry food storage shelves there was a partially eaten plate of fruit and a drinking cup next to fresh produce. DCS C stated the plate and cup had belonged to a staff person and should not have been left there. On the shelf under the counter was a food processor. The food processor attachment had dried food particles on it. Continued observation and interview of DCS C while temping pork loin for the noon meal revealed without performing hand hygiene or putting a beard net, he used his bare fingers to peel back strips of foil that covered the metal baking pan. He temped the pork, then cleaned the temping probe with a rag he had removed	S 450	ED will ensure that the form has been received and reviewed at the end of each week with randomly selected inspections of these tasks in the kitchen on a bi-weekly schedule. 10/7/2025 through 10/8/2025 the DSD addressed/removed (discarded)/corrected the following deficiencies brought to his attention by the surveyors: • Uncapped unlabeled squeeze bottles were discarded. • 1.5 liter bottles of coffee creamer were discarded and will not be replaced – only single us coffee creamer will be stocked. • Walk-in freezer was inspected and items out of compliance were discarded: metal pan of cooked meat covered in foil (pan cleaned/sanitized), sour cream container with orange contents, 5 bowels of uncovered ice cream, four bags of opened and unlabeled French fries, metal pan with two unmarked bags inside discarded (pan cleaned/sanitized). •Walk-in cooler was inspected and items out of compliance were discarded: plastic tub of moldy oranges – all produce in tub discarded and tub cleaned/sanitized, plastic tub of molded cabbage discarded and tub cleaned/sanitized. •Refrigerator was inspected and items of out compliance were discarded: 3 cans of uncapped whipped topping and one bottle of caramel topping discarded. •Cutting board shelf/rack cleaned. •Exterior and interior of microwave cleaned. •2 tubs of Baking potatoes with sprouts and/or discoloration were discarded –tubs were cleaned/sanitized. •Open sack of bread crumbs discarded. •Bag of moldy hot dog buns discarded. •Lids of plastic buckets in dry storage area secured. •Food Processor was cleaned.	

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S 450	Continued From page 19 from the sanitizing bucket. He stated he had been using that rag for cleaning the kitchen counters. He thought that using individually wrapped alcohol pads to clean the probe was more sanitary, but he had no packaged alcohol pads in the kitchen. DCS C thought the use of beard nets was contingent upon the length of a person's facial hair. He agreed that, regardless of facial hair length, it was best practice to keep facial hair covered when working around food. He also agreed that it was best practice to have washed his hands before her had peeled back the foil on the meat tray. DCS C stated he had past experience in food service, but he held no ServSafe certification. He was enrolled in a ServSafe certification program. There were no other kitchen staff who worked at the facility who were ServSafe certified. ED A had a current ServSafe certificate. 5. Interview on 10/7/25 at 3:45 p.m. with ED A regarding DCS C revealed she had hired DCS C in July 2025 and provided his orientation training. She was responsible for DCS C's supervision, and she was the only staff person who was ServSafe certified. DCS C was assigned the required on-line dietary training that was expected to have been completed within 30 days of his hire date. She did not think DCS C had completed any of that required training. She had reminded him as recently as 9/30/25 that he was expected to have completed that training. Refer to S506. ED A stated "she did not prioritize" monitoring the operation of the kitchen or DCS C's work	S 450	On 10/9/2025 the ED met with the DSD and educated on the following deficiencies related directly to the DSD as identified by the surveyors: • Hair/beard net use • Proper hand hygiene • Utensil/thermometer cleaning • Proper use of cleaning cloths • Providing tongs for use with food service to Memory Care for care staff to utilize when needed to ensure food is properly served. • ED provided the DSD with her study guides for the Serv Safe course to use as a source of reference to ensure ongoing compliance. ED also discussed with DSD the need for DSD to become ServSafe certified – this course will address such deficiencies for himself and others and give him the information and tools he needs to ensure his personal, and staff, continued compliance. • Dining Services Director was re-enrolled in the ServSafe Certification course on 10/20/25 and has been given until 11/10/2025 to successfully complete the course and obtain certification. Executive Director will obtain an update from DSD on a weekly basis on the status of completion of this course. To ensure that the DSD and all kitchen staff understood resident special diets and how to prepare them the following training/education was provided: Executive Director obtained updated resident diet report from Director of Resident Experience on 10/21/2025.	

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S 450	Continued From page 20 performance after he was hired. "He seemed to know his way around the kitchen." ED A stated consultations and interactions with the contracted registered dietician (RD) were all completed virtually. She had not known if the RD had any interactions with DCS C regarding kitchen operations since DCS C was hired. Review of the provider's August 2024 Director of Dining Services job description revealed: *"The Director of Dining Services will be responsible for overseeing kitchen operations while maintaining a safe and sanitary work environment..." *Duties and Responsibilities to Include: -"Make periodic and regular inspections of units to observe quality of food preparation and service, food appearance, and cleanliness and sanitation of production and service areas, equipment, and employee appearance." -"Receive periodic consultation from a Registered Dietician contracted by the Company..." -Complies with federal, state, and local health and sanitation regulations and department sanitation procedures..." Review of the provider's revised 11/11/22 Food Storage policy revealed: *"The facility will ensure that food will be stored under sanitary conditions." *"Expiration dates will be constantly monitored..." *Foods that have been opened or prepared will be placed in an enclosed container, dated and labeled. Opened food without a label will be discarded." *"Staff member food/beverages will not be stored in the kitchen cooler/freezer or dry storage area." Review of the provider's revised 8/3/22 Infection	S 450	On 10/22/2025 ED highlighted all residents on the report who had special/modified diets and presented the report to the Dining Services Director for his review. 10/22/2025 ED and DSD then updated the kitchen whiteboard where the special diets are posted for all staff. ED and DSD went over all of the resident special diets with all kitchen staff during staff meeting on 10/27/20025. All kitchen staff acknowledged their understanding. On 10/27/2025 the ED went over the communications from the Dietician with the DSD. ED educated the DSD on the process of the Dietician evaluating newly admitted residents and the reports that we receive via email from the Dietician communicating any change or modification to resident diets. ED educated DSD that these email communications must be read promptly by the DSD and any changes or additions to residents' diets must be communicated to all kitchen staff by the DSD and then posted on the kitchen whiteboard immediately upon receipt. To ensure ongoing compliance, monthly meetings between the DSD, ED and RD to review RD consultations will be held for six months beginning 11/12/2025. Meeting frequency will be re-evaluated at the 6-month mark and will be converted to quarterly if appropriate. The summary/minutes from these meetings will be shared at the quarterly QAPI meetings. Additionally, though the ED is currently included in the correspondence between the DSD and the RD, we will continue to utilize the Portal Hub in Dining RD, which allows for full visibility of any consultation, memo, or otherwise – which is updated in real time.	

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S 450	Continued From page 21 Control policy revealed "6. Dietary staff adheres to the Food Service Code including restraint of hair when handling food." Review of the provider's revised 8/1/22 Food Handling Procedure policy revealed "The facility will ensure that food will be handled in a manner that minimizes the risk of contamination." 6. Observation and interview on 10/7/25 at 10:15 a.m. with DCS C in the kitchen revealed the sanitizing chemical log for October 2025, consistently documented PPMs levels of 200 for all entries for breakfast, lunch, and dinner services each day that month. DCS C, felt that the dietary staff were potentially not checking the sanitizing levels and were writing down a number. DCS C tore off a piece of the sanitizer testing tape and held it in the sanitizing solution for 10 seconds. DCS C then compared that tape to the color reference chart, which indicated the sanitizing solution PPM solution was. He agreed that was not sanitizing solution level needed for sanitizing the dishes.. Sanitizer solution test tape instructions were posted above the three-compartment sink that read: "1. Obtain sample of sanitizer solution." "2. Allow sample solution to cool to room temperature. (75)." "3. When solution has cooled, dip test strip for 10 seconds. Do not shake. Compare colors at once. Maintain a 200 PPM to 400 PPM solution." "4. Check sanitizer strength often" DCS C stated he reviewed the sanitizing logs daily to ensure they were completed; however, he did not verify if the sanitizing solution levels were	S 450	ED instructed all kitchen staff during 10/27/2025 staff meeting that all special/modified/therapeutic diets must come from the kitchen properly prepared and be resident-specific. Kitchen staff were instructed to prepare and plate the food appropriately, place an insulated food-safe cover over the plate and label the cover with the resident's name (first name, last initial). Specific example of Resident 12 and mechanical soft diet was used for educational instruction purposes and specifically explained to the staff that in this instance, the meat portion will be cut into bite sized pieces and a moistening agent added by the kitchen staff, and the meal will leave the kitchen according to the dietary orders/guidelines. On 10/22/2025, ED presented DSD with the following documents for all kitchen staff to review and date/initial that they received, read and understood. These documents were presented to the ED during the 10/27/25 staff meeting, having been signed by all staff. The ED then laminated each document and placed on the kitchen communication board on 10/27/2025. Kitchen staff were notified that these documents would be posted on their communication board for reference at any time: • Mechanical Soft Diet (taken from Diet Manual) • Finger Food Diet Guide (obtained from Dietician) • Diet Summary (taken from Diet Manual) On 10/27/2025 the ED met with the Director of Dining Services and Director of Maintenance to address the ice machine located in the dining room. The Maintenance Director confirmed that the interior of the ice machine is cleaned on a weekly basis by maintenance staff and is monitored and documented through the TELS system.	

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S 450	Continued From page 22 within the required range for effective sanitizaion. Review of the provider's updated 8/1/22 Dietary policy revealed "the three-compartment system will be used to clean and sanitize utensils and equipment." 7. Observation and interview on 10/6/25 at 5:20 p.m. with RN D in the memory care unit (MCU) kitchenette revealed she was assisting with the residents' evening meal service. After performing hand hygiene, RN D removed a pair of gloves from her front smock pocket and put them on. She opened a plastic sack of bread, reached into that bag, and removed a piece of bread to place on a resident's plate. RN D agreed her gloves should have been removed from a glove box dispenser because her smock pocket may have been unclean. She stated she should have used clean tongs to remove the bread from the bag. Review of the provider's revised 8/1/22 Food Handling policy revealed: "The facility will ensure that food will be handled in a manner that minimizes the risk of contamination." "Proper utensils such as spatulas and tongs, or gloves will be used to handle foods."	S 450	Effective Monday, November 3, 2025, maintenance will include the inspection and cleaning of the exterior of the ice machine to address the lime build-up on the exterior of the unit. This will be added to the weekly maintenance task in TELS To ensure ongoing compliance, the Executive Director will choose randomly selected dates within the audit process and thereafter to personally observe the above areas and processes and ensure compliance and oversight by DSD and Maintenance Director. Audit/logs and/or observation notes will be shared at quarterly QAPI meetings for discussion/recommendation.	
S 468	44:70:06:06 Therapeutic Diets A facility that admits or retains any resident requiring a therapeutic diet, excluding low sodium diets, shall employ or contract with a dietitian. The dietitian shall approve written menus and diet extensions, assess the resident's nutritional status and dietary needs, plan individual diets,	S 468	DON reviewed all resident diet's ensuring chart correlated with current orders. Care staff will continue to receive online training and education related to residents' diet through EduCare courses assigned to them upon hire and annually.	11/3/2025

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S 468	Continued From page 23 and provide guidance to dietary personnel in areas of preparation, service, and monitoring the resident's acceptance of the diet. The frequency of dietitian consultations must be at least quarterly or sooner as determined by the resident's dietary need. 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 one of one observed resident's (12) meals were prepared and served in a manner that was consistent with her therapeutic diet order. Findings include: 1. Review of the resident list requested from executive director (ED) A on 10/6/25 at 9:00 a.m. during the entrance conference revealed the assisted living center (ALC) had two residents (6 and 13) with physician ordered therapeutic diets. 2. Observation on 10/6/25 at 10:00 a.m. in the kitchen revealed a list of residents with therapeutic diet information was posted on the wall near the serving window. "Mechanical soft" was listed beside resident 12's name on that list. 3. Observation and interview on 10/6/25 at 11:59 a.m. with unlicensed medication aide (UMA) M in the memory care unit (MCU) dining area revealed that resident 12 resided in the ALC, but chose to eat her meals in the MCU dining area with a family member who resided in the MCU. UMA M stated the residents who ate in the MCU dining area were either served a regular diet or finger foods (small, individual portions of food that	S 468	To ensure that the DSD and all kitchen staff understood resident special diets and how to prepare them the following training/education was provided: Executive Director obtained updated resident diet report from Director of Resident Experience on 10/21/2025. On 10/22/2025, ED highlighted all residents on the report who had special/modified diets and presented the report to the Dining Services Director for his review. On 10/22/2025, ED and DSD then updated the kitchen whiteboard where the special diets are posted for all staff. ED and DSD went over all of the resident special diets with all kitchen staff during staff meeting on 10/27/20025. All kitchen staff acknowledged their understanding. On 10/27/2025 the ED went over the communications from the Dietician with the DSD. ED educated the DSD on the process of the Dietician evaluating newly admitted residents and the reports that we receive via email from the Dietician communicating to use any change or modification to resident diets. ED educated DSD that these email communications must be read promptly by the DSD and any changes or additions to residents' diets must be communicated to all kitchen staff by the DSD and then posted on the kitchen whiteboard immediately upon receipt.	

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S 468	Continued From page 24 was eaten with the hands). No residents, including resident 12, required a therapeutic diet. 4. Continued observation on 10/6/25 at 12:15 p.m. of resident 12 in the MCU dining area revealed she was served an uncut slice of turkey, stuffing, and cranberry sauce for that meal. 5. Review of resident 12's care record revealed her 4/1/25 Brief Interview of Mental Status (BIMS) assessment score was 13. That indicated her cognition was intact. A 9/12/25 registered dietician (RD) note revealed, Quarter 3 Nutrition Modified Diet Review: Resident 12 "is on a regular diet w/[with] mechanical soft texture and regular consistency..." 6. Observation on 10/6/25 at 5:40 p.m. during the evening meal in the MCU revealed resident 12 was served a three-bean salad, soup, bread, tuna salad, and a cake dessert. Observation and interview on 10/8/25 at 12:15 p.m. with resident 12 in the MCU dining area revealed she was served mashed potatoes, a chicken breast that was cut into bite-sized pieces, and corn. Resident 12 stated she had dental problems that sometimes made it difficult to chew her food. She had a lower partial denture. She had seen her dentist regarding her dental problems, and was deciding whether or not to pursue dental interventions for those problems. Resident 12 stated she was not served a diet that was modified to accommodate her chewing problems. She cut her own food into manageable	S 468	ED instructed all kitchen staff during 10/27/2025 staff meeting that all special/modified/therapeutic diets must come from the kitchen properly prepared and be resident-specific. Kitchen staff were instructed to prepare and plate the food appropriately, place an insulated food-safe cover over the plate and label the cover with the resident's name (first name, last initial). Specific example of Resident 12 and mechanical soft diet was used for educational instruction purposes and specifically explained to the staff that in this instance, the meat portion will be cut into bite sized pieced and a moistening agent added by the kitchen staff and the meal will leave the kitchen according to the dietary orders/guidelines. 10/22/2025 ED presented DSD with the following documents for all kitchen staff to review and date/initial that they received, read and understood. These documents were presented to the ED during the 10/27/25 staff meeting, having been signed by all staff. The ED then laminated each document and placed on the kitchen communication board on 10/27/2025. Kitchen staff were notified that these documents would be posted on their communication board for reference at any time: • Mechanical Soft Diet (taken direct from Diet Manual) • Finger Food Diet Guide (obtained from Dietician) • Diet Summary (taken directly from Diet Manual) .	

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S 468	Continued From page 25 pieces, if that was necessary, and avoided foods she felt she was not able to safely chew. 7. Interview on 10/8/25 at 1:15 p.m. with cook I and culinary aide L regarding resident 12's dietary information posted by the service window revealed neither of those staff knew resident 12 was to be served a regular diet with a mechanical soft texture. Resident 12 was not served that modified diet. 8. Interview on 10/8/25 at 3:45 p.m. with ED A revealed she was not aware that the list of residents on therapeutic diets that she had provided was not accurate. Resident 12 was not served the therapeutic diet that was ordered by her medical provider. ED A was the only staff person who had a ServSafe Food Handlers certificate. Director of culinary services (DCS) C was hired on 7/21/25. He was responsible for overseeing kitchen operations. ED A supervised DCS C. She was responsible for ensuring he had followed the duties and responsibilities of his position which included knowing residents' diet needs and ensuring they had been accommodated. She confirmed resident 12's food was not being prepared and served according to her therapeutic diet order. Review of the provider's revised 9/26/25 DiningRD dietary manual diet descriptions (page 21) revealed the following regarding a mechanical soft diet: "This consistency modified diet is for individuals with limited or difficulty in chewing regular textured foods. This diet follows the regular diet planned and provides foods that can be easily chewed." "Foods should be fork tender. Meat is ground or chopped into 'bite-size' pieces	S 468	To ensure ongoing compliance, beginning November 3, 2025, the Executive Director will choose randomly selected dates within the audit process and thereafter to personally observe the preparation of the resident special diets and will ensure compliance and oversight by DSD. Beginning 11/12/2025, monthly meetings between the DSD, ED and RD to review RD consultations will be held for six months beginning 11/12/2025. Meeting frequency will be re-evaluated at the 6-month mark and will be converted to quarterly if appropriate. The summary/minutes from these meetings will be shared at the quarterly QAPI meetings. Additionally, though the ED is currently included in the correspondence between the DSD and the RD, we will continue to utilize the Portal Hub in Dining RD, which allows for full visibility of any consultation, memo, or otherwise – which is updated in real time. Audit/logs and/or observation notes will be shared at quarterly QAPI meetings for discussion/recommendation.	

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S 468	Continued From page 26 and should be mixed or served with gravy, broth or another type of moistening agent."	S 468		
S 485	44:70:06:11(1-3) ServSafe And Nutritional Needs The dietary manager, if employed, and at least one cook shall: (1) Successfully complete a ServSafe Food Protection Program and possess a current certificate; (2) Successfully complete the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association; or (3) Successfully complete equivalent training as determined by the department. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and job description review, the provider failed to ensure one of one director of culinary services (DCS) C and at least one employed cook had completed and possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 10/7/25 at 10:10 a.m. with DCS C revealed his hire date was 7/21/25. He had past food service experience, but he did not have a current ServSafe Food Protection Program certification. He stated he was enrolled in a ServSafe Food Protection course. No other kitchen staff were ServSafe certified.	S 485	Dining Services Director was re-enrolled in the ServSafe Certification course on 10/20/25 and has been given until 11/10/2025 to successfully complete the course and obtain certification. Executive Director will obtain an update from DSD on a weekly basis on the status of completion of this course. When completed, the Certificate will be collected and retained. Currently, our hiring manager (ED) is ServSafe certified and our DSD will be certified by 11/10/2025. The DSD is a cook and is scheduled to cook three shifts per week in our community. The combination of these two certified staff meet the regulatory standard, as confirmed by the surveyor on 11/4/2025.	11/10/2025

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S 485	Continued From page 27 2. Interview on 10/7/25 at 3:45 p.m. with executive director (ED) A regarding DCS C revealed she had hired DCS C and provided his orientation training . DCS C was assigned required on-line dietary training, which was expected to have been completed within 30 days of his hire date, but he had not completed it. DSC C was expected to complete the ServSafe Food Protection course after he was hired, but that had not occurred. ED A had not known that cook K's ServSafe certification expired. ED A had a current ServSafe Food Protection Progam certification, but "she did not prioritize" monitoring the operation of the kitchen or DCS C's work performance after he was hired. ED A stated, "He seemed to know his way around the kitchen." Refer to S506 and S450. Review of the August 2024 Director of Dining Services job description revealed preferred qualifications included ServSafe certification.	S 485		
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing;	S 506	A review of all active employee training transcripts was reviewed by Executive Director and Business Office Manager on 10/21/2025. On October 22, 2025, any employee non-compliant with training was notified that the required new-hire/onboarding training courses must be completed by November 1st.	11/21/2025

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S 506	Continued From page 28 (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel file review, interview, and policy review, the provider failed to ensure four of four dietary employees responsible for preparing and serving the residents meals completed the required dietary training within thirty days of hire (C, I, and J) and annuallym (K). Findings included: 1. Review of employee C's personnel file revealed he was hired on 7/21/25 as the director of culinary services. He had completed the nutrition and hydration training on 8/21/25. He had not completed the food safety, handwashing, food handling/preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling polices, time and temperature controls for food preparation and service, and sanitization required trainings. Review of employee I's personnel file revealed she was hired on 8/27/25 and was hired as a cook. She had not completed the food safety, handwashing, food handling/preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling polices, time and temperature controls for food	S 506	The Dining Services Director was notified via email from the Business Office Manager (cc ED) of the staff identified as not yet completing the required new-hire training within the first 30-days of employment and was notified of the November 1, 2025 deadline for completion. ED notified all supervisory staff on 10/21/2025 that all newly hired staff will not be scheduled to work in their respective departments until all of their online education requirements are completed. This will ensure that all staff complete the required education within the first 30-days of hire. Employee C completed the Dining, Nutrition and Food Safety portion of his new-hire/onboarding education on 8/21/25. Employee J completed the Dining, Nutrition and Food Safety portion of his new-hire/onboarding education on 3/17/2025. Through consultation with the Manager of Training and Customer Support for EduCare Training (Mirabelle Management), we confirmed that the Dining, Nutrition and Food Safety course (as well as the OSHA and Infection Control course) does include the required training listed below, which was also reviewed and confirmed with the CEO for this company. Though not specifically mentioned in the course syllabus, the required content below is included in the training/education that is provided to all staff. Additional documents included specific to this: •Food safety - content beginning on slide 39 through he remainder of the course •Handwashing - content slide 48. Content also covered in the course titled "OSHA and Infection Control" •Food handling/preparation techniques - content slides 20-33; 46-49; 51-52	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - SPEARFISH	6800 SAINT ONGE ROAD SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 506	Continued From page 29 preparation and service, nutrition and hydration, and sanitization required trainings. Review of employee J's personnel file revealed he was hired on 2/18/25 and was hired as a culinary aide. He had completed the nutrition and hydration training on 3/17/25. He had not completed the food safety, handwashing, food handling/preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling polices, time and temperature controls for food preparation and service, and sanitization required trainings. Review of employee K's personnel file revealed she was hired on 9/16/24 and was hired as a cook. She had not completed any of the required annual dietary trainings that included food safety, handwashing, food handling/preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling polices, time and temperature controls for food preparation and service, nutrition and hydration, and sanitization required trainings. Interview on 10/8/25 at 11:00 a.m. with executive director A revealed she was unaware the above dietary staff had not completed the required dietary training. Review of the provider's 2/15/2023 Dietary Inservice Training Policy revealed: "HME care communities will provide training to all dietary and food handling employees within 30 days of their hire date and annually thereafter." "The person in charge of dietary services, or the dietitian, shall provide ongoing in-service training for all dietary and food-handling employees. Topics shall include: *Food Safety	S 506	•Food-borne illnesses - content slides 39-45 •Serving and distribution procedures - content slides 15-17; 20-37 •Leftover food handling policies - content slide 46 •Time and temperature controls for good preparation and service - content slide 46; 49 •Sanitation requirements - content slide 47; 50 Employee K was assigned annual training by the Business Office Manager on 10/22/2025 and was given a deadline for completion of November 21, 2025 To ensure ongoing compliance with assignment and completion of new-hire and annual training, Business Office Manager will monitor/audit education transcripts weekly and will notify the appropriate supervisor via email (cc the ED) an update of all staff with incomplete education and will remind the supervisor of the deadline date for completion. Should any employees be found non-compliant on the deadline date given, Executive Director will individually discuss with the appropriate employees and disciplinary action will be executed, as necessary. Audit/logs and/or observation notes will be shared at quarterly QAPI meetings for discussion/recommendation.	

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S 506	Continued From page 30 *Handwashing *Food Handling and Preparation Techniques *Food-Borne Illnesses *Serving and Distribution Procedures *Leftover Food Handling Policies *Time and Temperature Controls for food Preparation and Service *Nutrition and Hydration *Sanitation Requirements"	S 506		
S 690	44:70:07:10 Emergency Opioid Antagonist Storage A facility may stock opioid antagonists for emergency use if the facility develops and implements written policies and procedures consistent with manufacturer guidelines for the safe storage and use. Opioid antagonists must be stored in a manner that allows access only to individuals qualified to administer the opioid antagonist. Qualified personnel may administer an opioid antagonist in accordance with the facility's policies and procedures. The facility must provide initial, and annual training to all personnel qualified to administer an opioid antagonist. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *A physician-ordered emergency over-the-counter medication for one of one sampled resident (2) was available for use by that resident. *All current staff had been trained on the use of Narcan (a brand name for intranasal naloxone, an antidote for a potential or actual opioid overdose) per the facility's policy.	S 690	Narcan was removed from the PRN Standing Orders. This medication will only be ordered by PCP as warranted. Our internal policy has been revised effective 11/3/2025.Only eligible staff are able to administer Narcan. Narcan education to be added and included as part of the Med Aides training upon hire and annually. The following Narcan education will be conducted for all staff eligible to administer medication at the staff meeting on November 13, 2025. The education will include; 1.Review the HMEC Naloxone Policy & Usage Report 2.Read the Naloxone training slides 3.Watch video https://youtu.be/D0ozzcxSbgc?si=y74NaleUUpXv2WA 4.Print Naloxone Usage Report for EVERY Narcan issued to a resident (when applicable) 5.Post the Opioid Signs/Symptoms/Treatment document in the med room 6.Post the About Opioids Fact Sheet in the med room	11/13/2025

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S 690	Continued From page 31 Findings include: 1. Review of resident 2's care record revealed her October 2025 medication administration record (MAR) included the following 9/24/25 physician's order: "Narcan spr [spray] 4 mg [milligrams]. Give 1 spray in nostril X 1 [once] for [an] overdose. May repeat in opposite nostril for no response X [after] 2 minutes." Her 9/25/25 hospital discharge orders included a physician's order for one tablet of 5 mg Oxycodone (an opioid medication used for pain management), to be administered three times daily. There was no physician's order for Narcan on those discharge orders. Interview on 10/7/25 at 5:10 p.m. with director of nursing (DON) B revealed she stated the above Narcan was to be kept inside a secured medication cart. She was not able to locate the original physician's order for resident 2's Narcan. DON B called the facility's pharmacy provider and was told that resident 2's Narcan order had originated from the resident's 9/24/25 standing orders (a list of commonly used medications approved for staff to administer to a resident to treat symptomatic conditions) form. The pharmacy had not provided Narcan to the facility for resident 2's Narcan standing order. DON B stated the above standing order form was a facility form provided to a physician to complete and return for all newly admitted residents. The form had included a standardized list of commonly used over-the-counter (OTC) medications that were not immediately available but were able to be secured from the pharmacy	S 690		

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S 690	Continued From page 32 within several hours of the pharmacy being notified. Once they were delivered, those medications could be administered for common physical complaints such as a dry throat or constipation. There were administration instructions for each of the medications listed on the standing order form. The physician checked a box beside each of those listed medications on that form that the physician approved for administering to that resident. Review of resident 2's 9/24/25 physician signed standing orders and continued interview with DON B revealed there was a check placed beside the Narcan. "Narcan: May administer emergency OTC Narcan (per manufacturer's instructions) in the event of an [opioid] overdose." DON B confirmed an opioid overdose was an emergent event. There was no Narcan available to administer resident 2 in the event of an actual or suspected opioid overdose. No staff had been trained in the use of Narcan according to the provider's policy. Review of the provider's 1/3/25 Naloxone policy revealed it was expected that "...all current staff be trained in the use of Naloxone." That training was expected to "be incorporated into initial employee training for all new employees and annually thereafter..."	S 690		
S 835	44:70:09:09(1) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life,	S 835	On October 22, 2025, the ED implemented additional dementia-focused training- this was assigned to all staff with a deadline for completion of November 21, 2025.	11/21/2025

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S 835	Continued From page 33 including: (1) A safe, clean, comfortable, and homelike environment; 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 care that contributed to the quality of life for one of one sampled resident (5) was provided by two of two staff members (E and M) who did not assist the resident with her toileting needs according to her care plan, which resulted in an incontinence incident in a recliner chair in the memory care unit (MCU) where other residents were present. Findings include: 1. Observation on 10/6/25 from 11:30 a.m. to 12:25 p.m. in the MCU at lunch time revealed three of the four tables in the dining area were occupied by residents. Some residents were talking with each other, and other residents were watching TV while they ate lunch. Resident 5 was seated in a recliner chair, between the nurses' station and the kitchenette She was wearing a white shirt, black pants, and no socks or shoes. Resident 5 was eating breaded chicken strips and french fries with her fingers. Observation on 10/6/25 at 4:33 p.m. in the MCU revealed that resident 5 was sitting in the same recliner chair as previously observed. She repeatedly pulled at the bottom of her white shirt, patted her stomach, and intermittently flapped her arms. The bottom of her white shirt appeared visibly wet. A noticeable odor of urine was present	S 835	This additional dementia training includes how to care for residents with behaviors or who may be combative, how to redirect, how to reapproach and redirect. This also focuses on Resident's on 2-3 hour toileting schedule will be recognized and ensured toileting attempts and if resident refuses, to reach out to another staff member or nurse for assistance. The toileting and re-directing procedures/techniques will be educated to staff by the DON during the November 13, 2025 all-staff meeting and routinely during care-staff meetings going forward. To ensure continued compliance and ongoing training, this additional dementia-related training has also been added to the annual training requirement for all staff effective 10/22/2025. Dementia – Activities – A Balanced Approach Dementia – Activities – Bathing Dementia – Activities – Chores, Working and Volunteering Dementia – Activities – Dressing and Grooming Dementia – Activities – Hydration, Nutrition, Eating and Dining Dementia – Activities – Exercise Dementia – Activities – Leisure and Life Enriching Activities Dementia – Activities – Medications, Vitals and Treatments Dementia – Activities – Toileting Dementia – Problem Solving – Anger & Aggression Dementia – Problem Solving – Anxiety Dementia – Problem Solving – Paranoia & Hallucinations Dementia – Problem Solving – Rummaging & Hoarding Dementia – Problem Solving – Wandering & Elopement	

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S 835	Continued From page 34 in the immediate vicinity of resident 5. Interview on 10/6/25 at 4:40 p.m. with unlicensed medication aide (UMA) M in the MCU revealed she had not assisted resident 5 to use the bathroom that afternoon. Interview on 10/6/25 at 4:45 p.m. with UMA E in the MCU revealed she was unable to assist resident 5 to the bathroom that afternoon. UMA E stated that resident 5 would sometimes get combative with the staff. UMA E stated that when that happened, she would ask registered nurse (RN) D for assistance. Interview and observation on 10/6/25 at 4:53 p.m. with RN D in the MCU revealed she would discuss with staff the appropriate medications for resident 5 as well as the appropriate approach for resident 5. RN D and UMA M assisted resident 5 out of the recliner and resident 5's pants were visibly wet. Additionally, the fabric covering and the seat of the recliner chair was wet. RN D stated that she was not approached by UMA E or UMA M for assistance in taking resident 5 to the bathroom that afternoon. Record review of resident 5's care record revealed she was admitted on 7/1/25, and her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) and Alzheimer's disease (a progressive disorder that affects memory, thinking, social abilities and body functions). Her care plan indicated for the Bladder/bowel area "Toileting every 2-3 hours, incontinent [of] bowel and bladder, assist of 1-2 [staff] and cueing."	S 835	Resident 5's care plan, specifically her toileting care task has been modified. Care task is timed for every 2 hours from 7:00am until 9:00pm for care staff to assist/cue resident 5 and monitor for bladder/bowel incontinence. Director of Nursing or Designee will review the resident's chart weekly for 3 months for completeness and follow-up by care staff. Additionally, Nurse or Designee will perform random ongoing checks on resident 5 to monitor for urine odor, being left for extended periods of time in one location, or signs of anxiety/agitation that are not addressed. During the random ongoing checks, real-time feedback, staff education/re-training, and/or remediation will be provided as needed.	

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S 835	Continued From page 35 For the Vision/hearing/Speech area "[Resident 5] Is unable to make [her] needs understood." For the Communication area "[The] Staff [are] to anticipate Resident [5] needs." Interview on 10/8/25 at 3:07 p.m. with director of nursing (DON) B regarding resident 5 revealed she expected the MCU staff to reapproach or have another staff member reapproach resident 5 if she was combative. DON B stated she also expected the MCU staff to reach out to the RN assigned in the MCU for assistance. Review of the provider's 7/21/22 Quality of Life policy revealed: "It is of the utmost importance that HME Care and our partners provide a quality environment and high quality of life for our residents." "HME Care will accomplish this by providing: 1. A safe, clean, comfortable, and homelike environment. 2. Maintenance or enhancement of the resident's ability to preserve individuality, exercise self-determination, and control everyday physical needs;" Review of the provider's updated 7/15/2022 Abuse and Neglect Investigation and Reporting policy revealed: "Neglect -the absence of the minimal services or resources required to meet basic needs. Neglect includes withholding or inadequately providing medical care and, consistent with usual care, treatment and services, food, hydration, clothing, or good hygiene. It may also include placing an individual in unsafe or unsupervised conditions."	S 835		