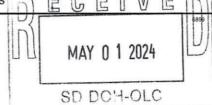
South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C R WING 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 Compliance Statement S 000 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 3/26/24 through 3/27/24. Peaceful Pines Senior Living-Fort Pierre was found not in compliance with the following requirements: S130, S169, S200, S296, S305, S337, S468, S503, S506, S633, S680, S685, S990, and S1039. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for The shared-use blood pressure cuff assisted living centers, was conducted from 5/8/24 has been sanitized. CNA/UMA M 3/26/24 through 3/27/24. The area surveyed was accidents. Peaceful Pines Senior Living-Fort and UMA O have been reeducated Pierre was found not in compliance with the on how to sanitize medical following requirement: S337. equipment when using shared medical equipment. All other staff S 130 S 130 44:70:02:09 Infection Prevention And Control will be educated at an All Staff Inservice on May 7-8, 2024, to The infection prevention and control program reeducate staff on this process and must utilize the concept of standard precautions the infection prevention and control as the basis for infection prevention and control. policy. Bloodborne pathogen control must be maintained The DON or a designee will according to the requirements contained in 29 conduct a weekly audit of 5 random C.F.R. § 1910.1030, in effect on April 3, 2012. staff across all shifts to ensure that The facility shall designate healthcare personnel shared medical equipment is to be responsible for the implementation of the infection prevention and control program properly sanitized between uses. including monitoring and reporting activities. Audits will begin on April 24, 2024, for 8 weeks through June 19, 2024, and continue monthly for 3 months through September 30, 2024. The This Administrative Rule of South Dakota is not results of these audits will be met as evidenced by: shared by the Director of Nursing or Based on observation, interview, and policy a designee at the facility's monthly review, the provider failed to ensure infection QAPI meeting. prevention and control practices were

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

Heather Janes

TITLE Administrator (X6) DATE 5/1/2024

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South Da	akota Department of He	ealth			PRINTED: 04/11 FORM APPR	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		80072	B. WING		C 03/27/2024	4
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PEACEFU	JL PINES SENIOR LIVING	G - FORT PIERRE	LLOWSTONE S' ERRE, SD 5753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMP	(5) PLETE ATE
S 130	Continued From page	1	S 130	UMA O was reeducated on the		
1 20 10 4	implemented for the f	following:		insulin administration policy and	the	
April 1	*Cleaning of a shared	I-use blood pressure cuff by		sanitary locations where insulin		
Angelows and	one of one certified n			be administered, as well as resid		
a de la companya de l		VUMA) (M) after it was		dignity rights. All other staff will I		
	used for one of one s			reeducated at an All Staff Inserv		
	*Maintaining a sanitai			on May 7-8, 2024, on this proces		
		hand hygiene by one of		and the insulin administration po		
A.		medication administration.		Our Infection Control policy was		
9	Findings include:			provided in an email to Sarah		
147	1 Observation and in	tan in an 2/20/24 at 2:22		Hendrickson on March 28, 2024		
		terview on 3/26/24 at 3:20				
		M while taking resident 4's		A weekly audit of each	. , . ,	
	blood pressure revea			applicable insulin-dependent res		
		ood pressure cuff from the		will be conducted by the Director		
		cart, took the resident's ig, then returned the blood		Nursing or a designee, to ensure		
×0	pressure cuff to the ca			insulin administration occurs in a	1	
		cuff should have been		sanitary setting, with staff perfor	ming	
	sanitized before return			proper hand hygiene, and in a		
	odinized belove retain	and it to the care.		dignified manner. Audits will beg	in on	
	2 Observation and in	terview on 3/27/24 at 6:30		April 24, 2024, and will be condu	ıcted	
		ng resident 3's medication		for 8 weeks through June 19, 20		
	administration in her b			and continuing monthly for 3 mo		
4	*While the resident wa	as sitting on the toilet UMA	1	through September 30, 2024. Th		
		ared insulin pen that she		results of these audits will be sha		
	then injected into her			by the Director of Nursing or a		
in the second	*After the insulin adm	inistration was completed		designee at the facility's monthly	,	
	UMA O removed her	gloves, washed her hands in		QAPI meeting.	1	
		m sink, and dried them with			ha	
	one of the resident's h			UMA O was reeducated on t	1.000	
	 A paper towel dispen 	ser hung on the wall next to		proper hand hygiene policy which		
	the sink.			includes using the single-use pa	per	

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*UMA O agreed a bathroom toilet was not a

*Disposable paper towels should have been used

dignified or sanitary place for insulin

to dry her hands after washing them.

Interview on 3/27/24 at 2:15 p.m. with administrator A regarding infection control

administration.

towels provided in each resident's

reeducated on this process and the

hand hygiene policy at an All Staff

room. All remaining staff will be

Inservice on May 7-8, 2024.

FORM APPROVED South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 130 Continued From page 2 S 130 The Director of Nursing or a designee will conduct a weekly revealed: *Director of nursing C was responsible for the audit to ensure that staff use proper facility's infection control program. hand hygiene. The audits will begin *Medical equipment shared by residents was on April 24, 2024, for 8 weeks expected to be cleaned after each resident's use. through June 19, 2024, and then *Medication administration was expected to occur continuing monthly for 3 months in a sanitary environment. through September 30, 2024. The *Paper towel dispensers were expected to be results of these audits will be used after handwashing occurred the in resident shared by the Director of Nursing or rooms. a designee at the facility's monthly Review of the 8/3/22 revised Cleaning of Shared QAPI meeting. Medical Equipment policy revealed "2. All common-use equipment shall be disinfected after each use." An Infection Control policy related to hand hygiene was requested from administrator A on 3/27/24 at 3:15 p.m. but was not provided by the end of the survey. S 169 S 169 44:70:02:17(5) Occupant Protection Our construction team (HME Care 5/1/24 Home Office in Brookings) was The facility shall: reeducated on the need for an electrically-activated audible alarm Install an electrically activated audible alarm, if required by other sections of this article, on any for the main entrance/exit. Our unattended exit door. Any other exterior door construction team is researching must be locked or alarmed. The alarm must be options to implement an alarm audible at a designated staff station and may not system that meets code as specified automatically silence if the door is closed; in 44:70:02:17(5). Until then, the main entrance/exit will be locked so that staff are aware of every person entering and exiting that door. This Administrative Rule of South Dakota is not The main entrance was locked

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met as evidenced by:

Based on observation and interview, the provider

failed to install an electrically activated audible alarm for the main entrance/exit. Findings

beginning on 4/24/24 and will remain

locked until an approved alarm

system is installed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:

(X3) DATE SURVEY COMPLETED

80072

B. WING

C 03/27/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1000 YELLOWSTONE STREET

(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 169	Continued From page 3	S 169	A solution to remedy the situation	
991 101	include:		will be shared with DOH by May 1,	
******			2024. The solution will include the	
***	1. Observation on 3/26/24 at 11:15 a.m. revealed		timeline for completion of an alarm	
4.00	the main entrance sliding doors did not alarm		installation as shared by the vendor. The	
1374	when opened from the motion-sensor inside the		Administrator or a designee will notify	
-1-	building. There was no receptionist at the		DOH once the alarm system is installed.	
	receptionist's station. There were no other		 The Maintenance Director or a 	
	provider staff seen in the area. Interview with the administrator on 3/26/24 at 11:30 a.m. revealed		designee will conduct daily audits to	
	there were several staff situated in offices along		ensure this entry stays locked until an	
	the corridor to the main entrance, including		approved alarm is installed. The results	
	herself. She stated the provider used Care	1	of these audits will be shared by the	
	Predict (a resident call system, geofencing		Director of Maintenance or a designee at	
	system, resident door key, and fall alert). The		the facility's monthly QAPI meeting.	
	Care Predict system and the staff office locations		Once an approved alarm is	
	did not meet the requirement to identify when a		installed, the Maintenance Director or a	
	cognitively impaired resident might possibly exit		designee will conduct a daily audit to	
- 74 (4"	the building.		ensure the door alarm is working	
en k			effectively. Audits will be conducted	
S 200	44:70:03:01 Fire Safety Code Requirements	S 200	daily for 2 weeks, then weekly for 8	
	Fook facility must make applicable for a fet.		weeks, and then monthly for 3 months.	
colo f	Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012		The results of these audits will be shared	
	edition in chapter 32 or 33. An automatic sprinkler		by the Director of Maintenance or a	
	system is not required in an existing facility		designee at the facility's monthly QAPI	
	unless significant renovations or remodeling of		meeting.	
	greater than fifty percent of the facility occurs,		The door audits will remain on the	
	provided that any existing automatic sprinkler		facility's monthly preventative	
	system must remain in service. An attic heat		maintenance audit checklist.	
	detection system is not required in an existing			
	facility unless significant renovations or		S 200	
	remodeling of greater than fifty percent of the		Carried Control Carried Control Contro	
	facility occurs.		The Director of Maintenance has	5/11/24
0	This Administrative Rule of South Dakota is not		contacted an electrical contractor to	
	met as evidenced by:		install an exit sign at the independent	
1	Based on observation and interview, the provider		garages and move the exit sign in the	
2000	failed to install exit signage as required (at the		east side of the dining room, to be	
2 (94)	independent garages and for the east side of the		completed by May 15, 2024.	

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FORM APPROVED South Dakota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 200 S 200 Continued From page 4 · If the electrical contractor cannot accommodate these updates dining room). Findings include: by May 11, 2024, the Administrator or a designee will share the 1. Observation on 3/25/24 at 2:35 p.m. revealed the hallway to the three independent living contractor's completion timeline with garages in the assisted living building had an DOH by May 11, 2024. illuminated exit sign over the locked door (into the The Administrator or a independent living building) adjacent to garage designee will notify DOH once the door G103. The door was locked and could only signs have been installed or moved be unlocked with a key fob. Interview with the as requested. administrator on 3/25/24 at 2:40 p.m. revealed the door lock would not release upon activation of the fire alarm system. The exit sign needed to be moved to the control door (into the assisted living building) adjacent to garage door G101 at the south end of the hallway. 2. Observation on 3/26/24 at 2:55 p.m. revealed the exit sign in the dining room area at the nurse's station could not be seen from the east/west corridor west of the dining room. The sign would need to be moved approximately three feet south. Interview with the administrator at the times of the observations confirmed those findings. S 296 All staff were given a timeline of S 296 44:70:04:04(1-11) Personnel Training 4/30/24 April 30, 2024, to complete their required 30-day training. The These programs must be completed within thirty days of hire for all healthcare personnel and must hospice care and abuse, neglect, include the following subjects: and misappropriation of resident property and funds training was (1) Fire prevention and response; assigned to every staff member (2) Emergency procedures and preparedness, with a timeline of April 30, 2024, to including responding to resident emergencies complete. and information regarding advanced directives;

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(5) Resident rights;

(3) Infection control and prevention;

(4) Accident prevention and safety procedures;

South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 296 Continued From page 5 S 296 The Assistant Administrator or a designee will audit the course (6) Confidentiality of resident information; completions on May 1, 2024, and (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms: follow up with any staff members (8) Nutritional risks and hydration needs of who have not completed their residents: courses to complete them (9) Abuse and neglect: immediately. The results of this (10) Problem solving and communication audit will be shared by the Assistant techniques related to individuals with cognitive Administrator or a designee at the impairment or challenging behaviors if admitted facility's QAPI meeting in May 2024. and retained in the facility; and The Assistant Administrator or (11) Any additional healthcare personnel education necessary based on the individualized a designee will conduct a weekly resident care needs provided by the healthcare audit for all courses assigned, to personnel to the residents who are accepted and ensure courses are completed retained in the facility. within the employee's first 30 days and annually. These audits will Any personnel whom the facility determines will begin on May 1, 2024, and will have no contact with residents are exempt from continue for 8 weeks through June the training required by subdivision (8). 30, 2024, and then monthly for 3 months through September 30, 2024. The results of these audits will be shared by the Assistant Administrator or a designee at the facility's monthly QAPI meeting. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, personnel file review, and policy review, the provider failed to ensure the following required employee training was completed: *Fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, resident rights, confidentiality of resident information, and incidents and disease reporting training for one of five sampled employee (I). *Abuse, neglect, and misappropriation of resident

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property and funds training for four of five

South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C 03/27/2024 80072 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 296 S 296 Continued From page 6 sampled employees (E, H, I, and J). *Training based on the individualized care needs of residents for five of five sampled employees (C. E. H. I. and J). Findings include: Interview and eview of the facility's 12/20/23 provisional license during the entrance conference on 3/26/24 at 11:30 a.m. with administrator A revealed: *The facility accepted residents for admission who received hospice services. -There were no residents currently on hospice but they had cared for residents who received hospice services. Review of personnel files and interview on 3/27/24 at 7:00 a.m. with administrator A revealed: *Employee C's hire date was 9/25/23. *Employee E's hire date was 12/15/23. *Employee H's hire date was 11/15/23. *Employee I's hire date was 2/5/24. *Employee J's hire date was 11/10/23. *Employees C, E, H, I, and J had not completed the required trainings referred to above. *Director of nursing C assigned employees their required training assignments using an online training program. -There was no process to ensure training assignments were completed. *Hospice training was available but had not been assigned through the online training program. Review of the 7/1/22 Personnel Orientation and Training Plan policy revealed: *Within 30 days after their hire date all employees were expected to complete a formal orientation program that included the following subjects: -Fire prevention and response;

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PRINTED: 04/11/2024 FORM APPROVED South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 296 S 296 Continued From page 7 -Emergency procedures and preparedness; -Infection control and prevention; -Accident prevention and safety procedures; -Resident rights: -Confidentiality of resident information; -Incidents and disease reporting; -Nutritional risks and hydration: -Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors; -Any additional training topics based on the individualized needs of residents accepted and retained in the facility. S 305 S 305 44:70:04:05 Personnel Health Program The facility process was immediately 5/124 updated to specify that for all newly-The facility shall have a personnel health program employed staff, the Communicable for the protection of the residents. All personnel Disease Screening Form will be must be evaluated by a licensed health printed by the Assistant professional for a reportable communicable Administrator, Director of Nursing, or disease that poses a threat to others before a designee to obtain approval and a assignment to duties or within fourteen days after employment including an assessment of previous signature from the Director of vaccinations and tuberculin skin tests. Nursing or a Registered Nurse designee. The Assistant This Administrative Rule of South Dakota is not Administrator or a designee will audit met as evidenced by: all personnel files to identify any staff Based on personnel file review, interview, and whose Communicable Disease policy review, the provider failed to ensure five of Screening Form had not been signed

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2024.

five sampled employees (C, E, H, I, and J) were

evaluated by a licensed healthcare professional

communicable diseases within fourteen days of

1. Personnel file review and interview on 3/27/24 at 7:15 a.m. with administrator A revealed: *Employee C's hire date was 9/25/23. *Employee E's hire date was 12/15/23.

and determined to be free from reportable

employment. Findings include:

by a Registered Nurse. These forms

will be printed, reviewed, and signed

by the Director of Nursing with a

completion target date of May 1,

PRINTED: 04/11/2024 FORM APPROVED South Dakota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 305 · A weekly audit will be S 305 Continued From page 8 conducted by the Director of Nursing *Employee H's hire date was 11/15/23. or a designee to ensure that the *Employee I's hire date was 2/5/24. Communicable Disease Screening *Employee J's hire date was 11/10/23. Forms are signed by the Director of *Each employee had a Communicable Diseases Screening form in their personnel file that Nursing or a Registered Nurse. included the following: These audits will begin on April 24, -A section of communicable disease screening 2024, for 8 weeks through June 19, questions answered by the employee. 2024, and then monthly for 3 months -A place for director of nursing (DON) C's through September 30, 2024. The signature acknowledging she reviewed the results of these audits will be shared answers to those screening questions. by the Assistant Administrator or a *There was no process to ensure either DON C designee at the facility's monthly or another licensed healthcare professional had QAPI meeting. signed the Communicable Diseases Screening form after the employee answered the communicable disease screening questions. Review of the 7/1/22 Personnel Orientation and Training policy revealed: *New employee paperwork included a Communicable Diseases Screening form. -It was the responsibility of the department managers or supervisors to ensure newly hired employees completed the new hire orientation paperwork before beginning their work assignments. An All Staff Inservice will be held on 5/8/24 May 7-8, 2024, to reeducate staff on S 337 S 337 44:70:04:11 Care Policies the following policies: 1. Fall Prevention and Response Each facility shall establish and maintain policies, policy, which includes the process for procedures, and practices that follow accepted

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monitoring vitals after a fall.

to UMAs versus UDAs.

Administration policy.

2. Insulin Administration policy,

Self-Administration policy and

including the appropriate delegation

the Nebulizer/Inhaler Treatment

to meet the residents' needs.

met as evidenced by:

standards of professional practice to govern care, and related medical or other services necessary

This Administrative Rule of South Dakota is not

Based on the South Dakota Department of Health

PRINTED: 04/11/2024 **FORM APPROVED** South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** COMPLETE. DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) · A weekly audit will be Continued From page 9 S 337 conducted by the Director of Nursing (SD DOH) event report reviews, record review, or a designee to ensure staff interview, and policy review, the provider failed to compliance with policies 1, 2, and 3 ensure: listed above. These audits will begin *The provider's policy and fall checklist procedure on May 1, 2024, for 8 weeks through for fall response was followed for two of three June 30, 2024, and then monthly for sampled residents (5 and 7) who had head injuries as a result of their falls. 3 months through September 30, *One of one unlicensed medication aide (UMA) 2024. The results of these audits will (O) correctly prepared an insulin pen for be shared by the Director of Nursing administration by one of one insulin dependent or a designee at the facility's monthly sampled resident (3). QAPI meeting. *One of one UMA (O) who dialed the insulin dose A weekly audit will be for one of one sampled resident's (3) insulin conducted by the Director of Nursing administration received unlicensed diabetic aide or a designee to ensure that all falls (UDA) training. are documented according to the fall *One of one certified nurse aide(CNA)/UMA (L) demonstrated correct inhaler administration for checklist and procedure, and that one of one sampled resident (4). the procedure was followed Findings include: accordingly. These audits will begin on May 1, 2024, for 8 weeks through 1. Review of the provider's SD DOH event report June 30, 2024, and then monthly for for resident 7 indicated on 2/10/24 he had two 3 months through September 30, falls. The first fall occurred at 9:30 a.m. The 2024. The results of these audits will second fall occurred at 11:30 a m. be shared by the Director of Nursing or a designee at the facility's monthly a. At 9:30 a.m. resident 7 and his friend went to QAPI meeting. the provider's salon for a haircut: *Resident 7 attempted to sit on the chair, but he missed the chair and fell. *He was not assessed by a nurse. *His vital signs and neuros had not been checked "due to him missing the chair with staff next to him - they helped him to the floor and then back up into the chair."

fall.

his room.

*No investigation was completed for the 9:30 a.m.

*After the haircut, resident 7's friend took him to

*UMA H stated it had been an hour or so before

-She left him in his recliner for a nap.

South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 03/27/2024 80072 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 337 S 337 Continued From page 10 the second fall that anyone had checked on him. Phone interview on 3/27/24 at 11:45 a.m. with administrator A and resident care aide (RCA) F regarding resident 7's 2/10/24 fall at 9:30 a.m. *RCA's F and D were working but they were not in the salon when resident 7 fell. *Only hair stylist N and resident 7's friend had been in the salon. -They "grabbed" resident 7 to prevent injury and moved him off the floor. *RCA F stated: -They were not sure if the fall checklist had to be filled out. -She did not know how to fill out the checklist. -They were not sure if the fall was a "true fall." -They had not seen it happen. -No vital signs had been taken. -They had not called the on-call nurse. b. Resident 7 had his second fall at 11:30 a.m.: *He had fallen backward in his room. *The fall was not witnessed. *UMA H had found him on the floor after he had cried out for help. -He had a skin tear to his left arm. -He stated he fell, hit his head, and was more confused than normal. *He had a Care Predict Wearable (used to alert the staff if he was moving), but the alarm had not alerted the staff. *UMA H called 911, then called the on-call registered nurse (RN) G to notify her of the fall. -The ambulance arrived before RN G. *His vital signs or neuros had not been checked until the ambulance had arrived. Interview on 3/27/24 at 12:10 p.m. with UMA H

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regarding resident 7's 2/10/24 fall at 11:30 a.m.

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	
		80072	B. WING		The second secon	C 27/2024
	PROVIDER OR SUPPLIER JL PINES SENIOR LIVING	G - FORT PIERRE 1000 YE	DDRESS, CITY, STATE LLOWSTONE STR ERRE, SD 57532			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 337	revealed: *UMA H found resider the wall. *She called 911 then *His vital signs and ne until the ambulance h Phone interview on 3/ resident 7's falls on 2/ *She had not received 9:30 a.m. fall, but she at the time. *She was called in for *She did not get the c -The ambulance arrive *She had not known a the ambulance was or emergency room follo *She confirmed the pr fall checklist had not b 2. Review of the provi for resident 5 indicate *UMA E and RCA D h resident 5 on the floor up with her head near *Resident 5 had a blee head. *UMA E applied a tow to stop the bleeding. *RCA D left the room to call 911. *UMA E remained with *Once the ambulance vital signs and neuros Review and interview	called on-call RN G. euros had not been checked ad arrived. 27/24 with RN G regarding 10/24 revealed: d a phone call regarding his should have been notified the 11:30 a.m. fall. all until after they called 911. ed before her. about the 9:30 a.m. fall until in their way to the wing the second fall. ovider's fall policy and the been followed. der's SD DOH event report d on 3/3/24 at 7:35 p.m. eard a crash and found in front of her chair, curled the wall. eding laceration on her el and pressure to her head to get medical supplies and in resident 5 and talked. arrived, the crew checked on 3/27/24 at 1:00 p.m. with	S 337			
1133 NO	administrator A regard Checklist revealed: *The vital signs had no	ing resident 5's Fall ot been obtained by UMA E				

South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED. IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C R WING 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 337 S 337 Continued From page 12 and RCA D. -They had not moved resident 5 off the floor. -The ambulance crew had placed her on a cart. *They had not notified the on-call nurse at the time of the fall. *Director of Nursing (DON) C was the on-call -She had arrived as the ambulance left with resident 5. *Resident 5 was taken to the hospital and remained there overnight. *Administrator A's expectation was UME E and RCA D should have obtained vital signs and notified the on-call nurse. Review of the provider's August 2023 Fall Response revealed: *If a fall occurred when a licensed nurse was not in the building or available to complete a physical assessment: Check for obvious signs of injury. -Obtain vital signs before the resident was moved. *Call the nurse for vital signs outside the standard parameters set by the resident's provider. *If the resident has obvious signs of injury needing emergency call 911 such as not responsive, or severe bleeding. *The nurse or the person who found/witnessed the fall would initiate the incident report and complete the post-fall investigation report. *Any witnesses to the fall should be asked for statements. *Implement immediate interventions as appropriate to prevent future falls. *Complete the fall checklist and return it to the DON. *Notify the family. *A nursing assessment should be completed and

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documented in the progress notes.

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET FORT PIERRE, SD 57532							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE		
S 337	check for bumps and *Obtain vital signs bef *If vitals are out of partheir head, or if the recall the on-call nurse a *Call 911 if the resider injuries that may requ *If the resident is unab	ecklist revealed: e/she is alright. e/she hit their head, and bruising, or bleeding. fore getting the resident up. rameters or the resident hit sident is on blood thinners, at the time of the fall. nt has obvious signs of ire emergency attention. ble to get up independently, t the resident's fall, vital of injury or pain.	S 337				

PRINTED: 04/11/2024 FORM APPROVED South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUII DING: C R WNG 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 337 | Continued From page 14 S 337 UMA O will complete UDA training 5/11/24 before assisting with administration of insulin. The Director of Nursing will reeducate UMA O on the facility's 3. Observation and interview on 3/27/24 at 6:45 insulin administration policy, including a.m. with UMA O preparing resident 3's insulin proper cleaning, priming, and insulin pen for self-administration revealed she: administration practices. The Director *Attached the needle onto the end of the insulin pen without first cleaning the top of that pen. of Nurisng will shadow UMA O for 1 -Knew the top of the pen was should have been week to ensure proper practices and cleaned with an alcohol pad before attaching the responsibilities are maintained with no needle. issues. *Failed to prime the pen before dialing the correct Additional UDA training will be number of insulin units to be administered. provided for eligible UMAs as -It was not her usual practice to prime the pen before dialing the correct insulin. determined by the Director of Nursing. *Was not a UDA. The DON will ensure that UDA training is completed before these 4. Observation and interview on 3/27/24 at 9:15 UMAs administer any insulin to a.m. with CNA/UMA L during and following residents. resident 4's inhaler self-administration revealed: The Director of Nursing has *The resident appropriately inhaled two puffs from the inhaler. reeducated CMA/UMA L on proper *Without first instructing the resident to rinse her self-administration of inhalers, and she mouth out after using the inhaler, CNA/UMA L or a designee will conduct a weekly gave the resident a cup of Juven (promotes audit of 5 random inhaler wound healing) powder mixed with water that the administrations to ensure the proper resident drank. administration technique was followed. *The budesonide/formoterol inhaler label These audits will begin on May 1, instructions read: "Rinse mouth after use." -CNA/UMA L knew she should have had the 2024, for 8 weeks through June 30, resident rinse her mouth out with water after

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2024, and then monthly for 3 months

results of these audits will be shared by the DON or a designee at the facility's

through September 30, 2024. The

monthly QAPI meeting.

using the inhaler but "she [the resident]

Interview on 3/27/24 at 7:45 a.m. with

sometimes refuses".

administrator A revealed:

COMPLETED

C

03/27/2024

South Dakota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _

80072

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

1000 YELLOWSTONE STREET

(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
S 337	Continued From page 15	S 337		
	*UMA O had not followed the facility's policy for			
Section 1	insulin administration which included proper			
	cleaning and priming of the insulin pen.			
-	*Tasks associated with resident 3's insulin			
	preparation and administration were not			
5.7	appropriate to delegate to UMA O who had not			
	completed the UDA training.			
	*CNA/UMA L had not followed the facility's policy			
	for inhaler administration which included			
	instructing the resident to "swish and spit" after inhaler use.			
	*Director of nursing C was responsible for CNA			
	and UMA oversight and supervision.			
	Dovinus of the undeted Insulin Injection Chille			
	Review of the undated Insulin Injection Skills Checklist revealed:			
	*"f. i) Insulin pen: Remove cover and wipe insulin			
	pen top with alcohol wipe and wait a few seconds			
Special Desiration	to dry" before attaching the need on the end of			
	the insulin pen.			
14	-"Prime needle by dialing pen to 2 units and			
	pushing the plunger until a small drop or stream			
	of insulin is seen."		n e ⁴ n	
	Daview of the 4/44/02 Unlicensed Dishetes Aids		and earn expension to	
	Review of the 1/11/23 Unlicensed Diabetes Aide			
	policy revealed "Location [the facility] will ensure that use of Unlicensed Diabetic Aides only occurs			
	after required education, training, and			
	competency requirements are met in alignment to			
	SD BON regulations."		The facility has signed a contractual	
	and the state of t		agreement with a Registered Dietician,	5/11/24
. 1	Review of the undated Inhaler Skills Checklist		who will begin working with staff	
	revealed "15. For steroid inhalers, provide	1	immediately. Together with the	
	resident with a cup of water and instruct to rinse		Registered Dietician and Director of	
10.00	mouth and spit water back into cup" after inhaler		Nursing, the Dietary Manager will audit	
	medication administration.		resident physician orders to identify all	
1			residents with a prescribed therapeutic	
S 468	44:70:06:06 Therapeutic Diets	S 468	diet.	

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South Dakota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING: _

(X3) DATE SURVEY COMPLETED

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	80072	B. WING	03/2	27/2024
	I PINES SENIOR LIVING - FORT PIERRE	REET ADDRESS, CITY, STA 000 YELLOWSTONE ST DRT PIERRE, SD 5753:	REET	
(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 468	Continued From page 16 A facility that admits or retains any resident requiring a therapeutic diet, excluding low sodiu diets, shall employ or contract with a dietitian. The dietitian shall approve written menus and diextensions, assess the resident's nutritional status and dietary needs, plan individual diets, 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 interview, observation, record review, job description review, and policy review, the provider failed to ensure physician orders for two of two sampled residents (1 and 3) with therapeutic diet orders were followed. Findings include: 1. Interview and review of the facility's 12/20/23 provisional license during the entrance conference on 3/26/24 at 11:30 a.m. with administrator A revealed: *The facility accepted residents for admission who required therapeutic diets. -There were no residents with physician-ordered therapeutic diets accepted for admission since the facility had opened. Observation on 3/26/24 at 5:00 p.m. and again of 3/27/24 at noon of resident 1 in the dining room revealed he: *Ate a patty melt sandwich during his evening meal on 3/26/24. *Ate scalloped potatoes with chunks of ham during his noon-time meal on 3/27/24.	e /	By 5/11/24, the Registered Dietitian will provide menu extensions and training to accommodate the identified therapeutic diets. The Director of Nursing will update the care plans for all residents with a prescribed therapeutic diet. An All Staff Inservice will be held on May7-8 2024, to reeducate staff on the Therapeutic Diet Policy. • An audit to ensure that all therapeutic diets are accommodated will be conducted by the Director of Nursing or a designee beginning immediately, weekly for 9 weeks through June 30, 2024, and then monthly for 3 months through September 30, 2024. The results of these audits will be shared by the Director of Nursing or a designee at the facility's monthly QAPI meeting. • As part of the facility's contractual agreement with the Registered Dietitian, she or another Registered Dietitian/designee will audit all residents' diet orders monthly to ensure that existing diets match current orders and are accommodated accordingly. The results of these monthly audits will be shared with the Director of Nursing and Dietary Manager. The Dietary Manager will share the audit results at the facility's monthly QAPI meeting.	

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PRINTED: 04/11/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 468 S 468 Continued From page 17 *Had no teeth. Review of resident 1's electronic medical record (EMR) revealed his: *Admission date was 1/3/24. *Physician Admission Orders-AL (assisted living) signed on 12/4/23 included the following diet order: diabetic/soft. *Physician order summary reviewed on 3/27/24 indicated the following diet order: diabetic diet, ground meat texture. Interview on 3/27/24 at 12:45 p.m. with resident 1 revealed: *He was unable to chew hard chunks of food because he had no teeth. -He chose not to wear dentures. *He was diabetic but was not receiving a diabetic diet or soft foods with ground meats. 2. Review of resident 3's EMR revealed her: *Admission date was 2/12/24. *Physician Admission Orders-AL signed on 2/6/24 included the following diet order: diabetic diet. Interview on 3/26/24 at 4:40 p.m. with head chef B regarding therapeutic diets revealed: *"We do not do therapeutic diets." -Director of nursing (DON) C was responsible for notifying him if a resident had a therapeutic diet ordered. *He was not aware residents 1 and 3 had

Interview on 3/27/24 at 2:15 p.m. with

therapeutic diets ordered.

of the other residents.

-They were served the same regular diets as all

*The facility used an agency called "Dining RD" [registered dietician] that only reviewed and signed off on their regular diet menus.

South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 03/27/2024 80072 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 468 S 468 Continued From page 18 administrator A regarding therapeutic diet orders revealed: *She was not aware residents 1 and 3 had therapeutic diets ordered. *Physician diet orders were expected to be entered into a resident's EMR by DON C. -She was responsible for notifying head chef B of those orders so they were implemented. *Dietician consultation services did not include therapeutic diets resulting in residents 1 and 3 not receiving: -Therapeutic diet menu development support from an RD. -Dietary assessment, dietary monitoring, and consultation from an RD. Review of the 7/18/22 Head Chef Job Description revealed duties and responsibilities included becoming "familiar with specific requests and diets of each resident, as well as changes in diet orders or resident abilities." Review of the 8/1/22 Medication and Treatment Orders policy revealed "2. Medication and treatment orders will be promptly noted and implemented." Review of the revised 8/1/22 Therapeutic Diets policy revealed: *"This facility will employ or contract the services of a registered dietician if the facility admits or retains any resident requiring a therapeutic diet." -Therapeutic diets included diabetic diets and ground meat diets. *"The registered dietician will approve written menus and diet extensions, assess the resident's nutritional status and dietary needs, plan individual diets, and provide guidance to dietary staff in areas of preparation, service, and monitoring the resident's acceptance of the diet."

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If continuation sheet 19 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		80072	B. WING		03/27/2024
	ROVIDER OR SUPPLIER	- FORT PIERRE 1000 YE	DDRESS, CITY, STA LLOWSTONE ST ERRE, SD 57532	REET	and a state of the second
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 503	The person in charge possess a current cer (1) A ServSafe Food (2) The Certified Foo Sanitation Course from Association; or (3) Equivalent training department. This Administrative Rumet as evidenced by: Based on interview, p policy review, the provide department and completed and poservSafe Food Protect Findings include:	Protection Course; d Protection Professional's in the Dietary Managers g as determined by the ule of South Dakota is not ersonnel file review, and vider failed to ensure the at least one employed cook basessed a current etion Program certificate.	S 503	Two staff members from the fa will take the required ServSafe Protection Course titled, "ServS Manager Course," which meets requirements of 44:70:06:16(1-Courses will begin no later than 1, 2024, to be completed by Ma 2024. The Assistant Administrator of designee will audit the ServSafe course completions on May 11 2024, and follow up if the two designated team members have completed the course to complete them immediately. The results audit will be shared by the Ass Administrator or a designee at facility's QAPI meeting in May 2024.	Food Safe so the
	ServSafe certificates. Review of head chef I	ary department. essed current, required and cook P's personnel 3/27/24 at 7:30 a.m. with			
	administrator A reveal	ed Head chef B and cook P Food Handling Program			

Review of the 8/1/22 revised Dietary Department

[17] [17] [17] [17] [17] [17] [17] [17]	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	CO	TE SURVEY MPLETED
		80072	B. WING		C 03/27/2024
	ROVIDER OR SUPPLIER	- FORT PIERRE 1000 Y	TADDRESS, CITY, STA FELLOWSTONE ST PIERRE, SD 5753	TREET	* *
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 503	policy revealed "1. The managed by a staff managed by a staff managed Protection Profession Profession the Dietary Management of the Protection Profession	e Dietary Department is ember who is certified from ection Course, the Certified essional's Sanitation Course agers Association, or termined by the SD [South	S 503		
S 506	The person in charge dietitian shall provide for all healthcare person food-handling service completed within thirty for any dietary or food must include the follow (1) Food safety; (2) Handwashing; (3) Food handling and (4) Food-borne illnes (5) Serving and districe (6) Leftover food hand (7) Time and tempera preparation and service (8) Nutrition and hydrogy Sanitation requires	d days of hire and annually d-handling personnel and wing subjects: d preparation techniques; ses; bution procedures; dling policies; ature controls for food ce; ation; and	S 506	All staff have been assigned the required Dietary Inservice Training with a completion timeline of April 30, 2024. The Assistant Administrator or a designee will audit the dietary inservice course completions on May 1, 2024, and follow up with any staff members who have not completed the course to complete them immediately. The results of this audit will be shared by the Assistant Administrator or a designee at the facility's QAPI meeting in May 2024. The Assistant Administrator or a designee will audit the dietary inservice course completion ensure training is completed within the employee's first 30 days and annually. These audits will begin on May 1, 2024, and will continue for 8 weeks through June 30, 2024, and then monthly for 3 months through September 30, 2024. The results of	4/30/24
	policy review, the prov	vice training (food safety, andling/preparation		these audits will be shared by the Assistant Administrator or a designee at the facility's monthly QAPI meeting.	

8NZ511

PRINTED: 04/11/2024 **FORM APPROVED** South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 506 S 506 Continued From page 21 distribution procedures, leftover food handling, documentation of temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements) was completed by one of three sampled food service employees (K) within 30 days after employment. Findings include: 1. Review of cook K's personnel file and interview on 3/27/24 at 7:30 a.m. with administrator A revealed: *Cook K's hire date was 1/29/24. *She was assigned the required dietary training topics to complete. -She had not started those trainings. *Head chef B was responsible for ensuring newly hired kitchen employees had completed their required dietary training within 30 days of employment. -There was no process to ensure training assignments were completed. Review of the revised 8/1/22 Dietary Inservice Training policy revealed: *"The person in charge of dietary services, or the dietician, shall provide ongoing in-service training for all dietary and food-handling employees." *The training topics included the nine topics referred to above.

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S 633

The Director of Nursing has

on May 7-8, 2024.

reeducated UMA O and UMA L on the proper labeling and storage of all

medications. All other staff will be

reeducated at an All Staff Inservice

5/8/24

and annually."

*"The training shall be provided to any dietary or food-handling employee within 30 days of hire

S 633 44:70:07:04 Storage And Labeling Of Medications

A container with a medication that will not be

used within thirty days of issue or with contents

that expire in less than thirty days of issue must

bear an expiration date. If a single-dose system is

South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: C R WING 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 633 S 633 Continued From page 22 The Director of Nursing or a designee will audit all insulin pens, used, the medication name and strength, inhalers, and bottled/contained expiration date, and a control number must be on medications to ensure the presence the unit dose packet. of "opened" or "expires" dates. This audit will be completed by May 1, 2024, and the results of the audit will be shared at the facility's This Administrative Rule of South Dakota is not QAPI meeting in May 2024. met as evidenced by: The Director of Nursing or a Based on observation, interview, and policy designee will audit all insulin pens, review, the provider failed to ensure: inhalers, and bottled/contained *One of one sampled resident's (3) insulin pen medications to ensure the presence was dated when it was opened or had a use by of "opened" or "expires" dates. These date according to the manufacturers' instructions. *One of one sampled resident's (4) inhaler was weekly audits will begin on May 1, labeled with a date when it was opened. 2024, and will continue for 8 weeks Findings include: through June 30, 2024, and then monthly for 3 months through 1. Observation and interview on 3/27/24 at 6:30 September 30, 2024. The results of a.m. with unlicensed medication aide (UMA) O these audits will be shared by the while she was preparing resident 3's morning Director of Nursing or a designee at medication pass revealed: the facility's monthly QAPI meeting. *The resident was scheduled to receive 30 units of Levemir insulin. *The insulin pen had a label that indicated it expired 42 days after it was opened but there was no open date on the inuslin pen. 2. Observation and interview on 3/27/24 at 9:15 a.m. with certified nurse aide/UMA L while she was preparing resident 4's morning medications revealed: *The resident was scheduled to take two puffs from her budesonide/formoterol inhaler. *Manufacturer's instructions on the inhaler box indicated the inhaler was to be discarded three months after opening. -There was no open date on the inhaler label. Interview on 3/27/24 at 2:30 p.m. with

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		80072	B. WING		C 03/27/2024
1	PROVIDER OR SUPPLIER JL PINES SENIOR LIVING	- FORT PIERRE 1000 YE	ADDRESS, CITY, ST LLOWSTONE S IERRE, SD 5753	TREET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 633	administrator A regard revealed: *Director of nursing C ensuring medications opened and expiration medications were che *UMAs were responsil medications were not *Resident 3's insulin p were not properly labe Review of the 8/1/22 S of Medications policy r drugs will be kept in the dispensed by the phar prescription label with including resident nam of drug and strength, operacription date, and 44:70:07:08 Medication Administration A facility shall establish policies and procedure medication administration physician, physician as practitioner's orders to medication administer resident's care record individual administering. This Administrative Rumet as evidenced by: Based on record review	was responsible for were properly labeled with dates when those cked into the facility. Dele for notifying DON C if appropriately labeled. Len and resident 4's inhaler led. Security and Accountability evealed "5. Prescription e original container macy bearing the original legible information e, physician name, name lirections for use, expiration date." In Records And In and implement written es to check the resident's cion records against the seistant, or nurse verify accuracy. Each ed must be recorded in the and signed by the	S 633	The Director of Nursing has reeducated CNAs/UMAs L and the Medication Records and Administration policy and process which includes the process to document medication errors and protocol to administer nebulizer treatments, specifically Residen nebulizer orders. All other staff or reeducated at an All-Staff Inservation on May 7-8, 2024. The Director of Nursing has notified the resident's provider at the medication error. The DON or a designee will conduct weekly audits on all resident will begin on May 1, 2024, and we continue for 8 weeks through Ju 2024, and then monthly for 3 medication of the second through September 30, 2024. The results of these audits will be she by the Assistant Administrator of designee at the facility's monthly QAPI meeting.	dure, d the t 2's will be vice bout ll ident tion audits will ine 30, onths ne ared r a

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	MULTIPLE C	ONSTRUCTION	4	C
		80072	B. V	VING		03/	27/2024
NAME OF PE	ROVIDER OR SUPPLIER		REET ADDRESS				V 1041 11 K (80)
PEACEFU	L PINES SENIOR LIVING	G - FORT PIERRE	000 YELLOWS		EET		
	NAMES OF THE STREET,		ORT PIERRE,	SD 57532	CATTERIAN CONTROL SERVICE SERV	SAME AND DESCRIPTION OF THE PROPERTY OF THE PR	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
S 680	Continued From page	24	S	680			
	medication aides (CN documented a nebuli: administered for one	urse aides/unlicensed IA/UMAs) (L and E) had no zer treatment was of one sampled resident (2 edication was not available	2)				1.0
	Administration Record 3/26/24 at 4:10 p.m. v medication cart reveal *Resident 2 had two residents.	2's March 2024 Medication of (MAR) and interview on with CNA/CMA E at the alled: nebulizer treatment orders: 1 vial via neb [nebulizer] to					
	times daily"(AM, noor *The ipratropium/albu stored in the medicati -CNA/CMA E was told	. "Inhale 1 vial via neb fou n, PM, and evening). terol nebulizer vials were on cart.	r				2 00
	*CNA/CMA E set up a	n and interview with dent 2 in his room revealed and started the resident's pium/albuterol nebulizer	d:				
	resident's room so the nebulizer treatment w *Resident 2 was awar	re of only one nebulizer heduled to take and he	de				
	-He kept an Albuterol *CNA/CMA E docume the PM budesonide no administered because available.	inhaler on his bedside table ented on resident 2's MAR ebulizer was not the medication was not the MAR his 3/26/24 AM					100

South Dakota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMPLETED
	6 .		B. WING		С
		80072	B. 111110		03/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
PEACEFU	IL PINES SENIOR LIVING	- FORT PIERRE	LOWSTONE ST ERRE, SD 57532		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
\$ 680	Continued From page administered.	25 ation was not administered.	S 680		
		to anyone the medication			
2	interview on 3/27/24 a L regarding the storag budesonide vials in his				
	the resident's bedside *After comparing the la to the resident's MAR inhaler and the budes not the same medicati	table as his budesonide. abel on the Albuterol inhaler she agreed the Albuterol onide nebulizer vial were on. mented on the resident			
,	*That was a medicatio				
5 8 4 2		Medication Administration is checklist revealed the for medication		r r wee eare the begin	- I
e e	 Medications must b the prescriber's orders Always know what r administered. 				
		tions. er against the medication			
	label three times prior medication to verify the right medication route	e right medication and the			
	Orders policy revealed *"7. If medication assis	stance and/or completed as prescribed,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLI A. BUILDING:	(X3) DATE SUF COMPLET			
		80072		B. WING		03/27/	/2024
	ROVIDER OR SUPPLIER	G - FORT PIERRE	1000 YELL	OWSTONE STREET, SD 5753	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 680	Reason Follow up procedure notification of pharma notofication of provide Medication errors valicensed nurse, admir	res, which may include acy, notification of nurse er.	e,	S 680	The Director of Nursing has reeduce CNA/UMA E, UMA O, and CNA/UMA E, UMA E	other eaff ete self- 2, 3, and	5/8/24
S 685	perform self-administre medications. At least registered nurse, or the physician assistant, or determine and record appropriateness of the self-administer medic. The determination muresident or healthcare for storage of the medicumentation of its awith this chapter. Any resident who storesident's room or self must have an order frassistant, or nurse preself-administration. This Administrative Rimet as evidenced by: Based on interview, reand policy review, the	egnitive ability to safely ration, may self-administer practitioner shall the continued e resident's ability to ations. Just state whether the expersonnel is responsibilitation and include administration in accordance a medication in the lf-administers a medication and physician, physician and physician and physician and physician actitioner allowing the provider failed to ensisted to self-administer residents.	ster , all ble dance ation, cian	S 685	The Director of Nursing will au resident charts to identify (1) those physicians have approved self-administration of medications have appropriately assessed and are administering medications according facility policy, and (2) those whose physicians have denied the ability to administer medications are not self-administering medications as present The Director of Nursing will update resident care plans accordingly. This be completed no later than April 30 • The Director of Nursing or a dwill audit all resident MARs to ensure self-administration of medications in out in accordance with provider ord the facility's Self-Administration of Medications policy. These audits won May 1, 2024, and will continue to weeks through June 30, 2024, and to monthly for 3 months through Septe 30, 2024. The results of these audits shared by the Director of Nursing of designee at the facility's monthly Queeting.	whose been g to o self- ribed. e these is will all g 2024. designee cure that is carried ders and f ill begin for 8 hen ember is will be r a	
	self-administered a ne	ebulizer treatment.					1 72

STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The state of the s	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
2		80072	B. WING		- 1	C 27/2024		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET FORT PIERRE, SD 57532							
PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
S 685	*One of one sampled self-administered insu *One of one sampled self-administered an i Findings include:	resident (3) who ilin. resident (4) who	S 685					
	provisional license du conference interview o with administrator A re	on 3/26/24 at 11:30 a.m. evealed: residents for admission their medications.						
	nurse aide (CNA)/unlin (UMA) E during admir nebulizer treatment in *Opened a vial contain solution, poured it into nebulizer mouthpiece, -Handed the nebulizer and turned on the neb resident's treatment.	6/24 at 4:10 p.m. of certified censed medication aide nistration of resident 2's his room revealed she: ning budesonide nebulizer the medication cup on the and closed the cup. It mouthpiece to the resident rulizer machine to start the resident to complete the						
	Review of resident 2's (EMR) revealed his: *Admission date was 3 *Physician Admission signed on 3/8/24 indic self-administer medica *Medication self-admir completed on 3/13/24 -"Resident needs assister. Able to know whe	Orders-AL (Assisted Living) ated he was able to ations. histration assessment						

keep in room, all other medications will be kept in

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	T I	COMPLETED
		80072	B. WNG		C 03/27/2024
	ROVIDER OR SUPPLIER JL PINES SENIOR LIVING	G - FORT PIERRE 1000 YEI	DDRESS, CITY, STATE LLOWSTONE STRI ERRE, SD 57532	Medical Action Control of the Contro	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
S 685	medcart [medication medaids [UMAs] or R	cart] and administered by N [registered nurse]". to safely self-administer his	S 685		
	a.m. with UMA O duri administration in her *UMA O attached the insulin pen then diale administered. -Handed the insulin p *After injecting the insuling resident 3 handed the *The resident and UM	needle onto the end of the d the correct dose to be			
	indicated she was not medications. *Medication self-admic completed on 2/13/24 -"Resident is able to sneeds assistance with administration of multi-	2/12/24. Orders-AL signed on 2/6/24 table to self-administer inistration assessment indicated: self-administer injections, a timing, dosing, and correct in medications. Ty Team Committee) feels f-administer listed as marked. sident may NOT			
	inhaler revealed: *After shaking the inh to the residentThe resident adminis	27/24 at 9:15 a.m. of dministration of resident 4's aler CNA/UMA L handed it stered two puffs as ordered haler back to CNA/UMA L.			100 200 U

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER:

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION
A. BUILDING:

C

B. WING

O3/27/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(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 685	Continued From page 29	S 685		
	Review of resident 4's EMR revealed her:			
	*Admission date was 1/30/24.			
	*Physician Admission Orders-AL signed on			
	1/29/24 indicated she was able to self-administer			
	medications.			
	*Medication self-administration assessment			
	completed on 1/31/24 indicated:			
-	-"Medications administered by RN and UMAs as			
0.00	ordered by physicians". *IDTC feels resident is safe to self administer			
*1. *1	listed medications? "No" was marked.		H H	
430.41	*Physician order: "Resident may NOT self			
-1 1-	administer medications" was marked.	1		
		1		
287 294	Interview on 3/27/24 at 2:25 p.m. with			
-	administrator A regarding the medication			
	self-administration process revealed:			
	*Residents 2, 3, and 4 self-administered the			
	medications referred to above but were not assessed.			
	*Director of nursing (DON) C was responsible for			
	the completion of medication self-administration	1		
	assessments.		and the second second second second	
	*Residents without a physician's order and an	-		
	assessment that supported their ability to safely			
21 (47)	administer their medication should not have			
	administered those medications.			
	Review of the 11/4/22 Self-Administration of			
	Medications policy revealed:	1		
	*"3. Residents who wish to self-administer		= 11 =	
	medications will be supervised to ensure safety.	1		
	 -a. Licensed nurse will use PCC (Point, Click, 			
	Care-electronic health record) Medication			
	Self-Administration Safety Screen to evaluate			
	safe self-administration of medications and			
	document continued appropriateness of the resident's ability to self-administer medications."			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						С	
		80072		B. WING			7/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		* **** 10 ×**
PEACEFU	IL PINES SENIOR LIVING	- FORT PIERRE		OWSTONE ST RE, SD 57532			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 990 S 990	44:70:10:21(1) Ventilal The ventilating system temperatures, minimulair per hour, minimum relative humidities as (1) For all occupied a able to maintain a min seventy-five degrees centigrade at winter d minimum of at least to hour. Each air supply must be mechanically ventilation air intake, room unit, must be loo practicable but not less	ating Systems Ins must maintain Im air changes of outdo In total air changes, and Ifollows: In eas, the facility shall be Inimum temperature of Fahrenheit or 23.9 deg I esign conditions with a I wo total air changes per I and air exhaust system I operated. Any outdoor I other than for an individuated as far away as I set than twenty-five feet I plumbing vent stack ar	rees	S 990 S 990	The Director of Maintenance he contacted an HVAC contractor install a fresh air supply and expenditation system in the memory unit storage room and a mechanist ventilation system in AL 117, and the memory care room. • The Administrator or a dewill share the contractor's combined timeline for installation of these ventilation systems with DOH 10, 2024. • The Administrator or a dewill notify DOH once the system installations have been complete.	r to xhaust ory care anical AL 107, laundry esignee ipletion e by May	5/10/24
	combustion equipmer outdoor intake serving be located as high as three feet or 0.91 met Each mechanical vendesigned and balance and safe pressure related areas to preclude the assure the health of the supply air inlet, recirculated the must be located opening not less than above the floor. A consupply air to or exhauthat air from a corrido bathroom, a toilet root opening directly on the exhaust ventilation must be located opening directly on the	nt. The bottom of any g a central air system m possible but not less the ers above the ground letilation system must be end to provide make-up a stionships between adjusted of infections and excupants. Each roculation inlet, and exhaud with the grill or diffuse three inches or 0.08 m ridor may not be used to st air from any room, extra may be used to ventilation, or a janitor's closet e corridor. Mechanical ust be provided in all soft rooms, and clean store	nan evel. air acent d om st air r eters o xcept ate a				

PRINTED: 04/11/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 80072 03/27/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 990 S 990 Continued From page 31 ventilation may be reduced or discontinued if the health and comfort of the occupants are not compromised; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install exhaust ventilation for three of three storage rooms and one laundry room. Findings include: 1. Observation on 3/26/24 at 11:30 a.m. revealed the memory care unit had a storage room with office equipment for the assistant director of nursing. The room was over 100 square feet in area and was not equipped with fresh air supply and exhaust ventilation to maintain two air changes per hour in the room. 2. Observation on 3/26/24 beginning at 11:45 a.m. revealed the storage rooms adjacent to resident rooms AL107, AL117, and the memory The Director of Maintenance has care laundry room (considered a wet room) were 5/10/24 contacted a generator servicing not equipped with mechanical exhaust ventilation. contractor to install a generator 3. Interview with the administrator at the time of enunciator in a 24-hour manned the observations confirmed those conditions. location. The Administrator or a designee S1039 S1039 44:70:10:32 Electrical Distribution System will share the contractor's completion timeline for installation of a generator

2024.

8NZ511

completed.

enunciator with DOH by May 10.

will notify DOH once the generator

enunciator installation has been

The Administrator or a designee

A facility with 17 beds or larger shall be equipped

with an emergency electrical service that includes

facility with 17 beds or larger shall have automatic

transfer switches serving emergency panels. A

emergency lighting for each exit way, staff work

areas, dining room, medication room, dietary

an automatic generator set and automatic

PRINTED: 04/11/2024 **FORM APPROVED** South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ C B. WNG 03/27/2024 80072 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S1039 S1039 Continued From page 32 department, medication room, room where main entrance electrical panels are located, boiler room, and exterior lighting serving required exits. A facility with 17 beds or larger shall have automatic emergency power for the fire alarm system, electrical receptacle servicing computers containing resident care records, telephone system, door alarms, and staff call system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to have a generator annunciator in a 24-hour manned location (electrical room on the main floor). Findings include: 1. Observation on 3/26/24 at 3:45 p.m. revealed there was no annunciator for the generator. There was no annunciator at a continuously occupied space (nurse's station, for example) that would indicate when the generator was in a trouble Interview with the administrator on 3/26/24 at 4:15 p.m. confirmed that finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Schools and copy of exception and a history copy of the copy of th	A. BUILDING:	BUILDING:		0
		80072	B. WNG			-C 28/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PEACEFU	L PINES SENIOR LIVING	G - FORT PIERRE	OWSTONE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	Administrative Rules 44:70, Assisted Living all previous deficienci Peaceful Pines Senio found not in complian requirements: S169, S1039. 44:70:02:17(5) Occup The facility shall: (5) Install an electrical if required by other secunattended exit door. must be locked or ala audible at a designate automatically silence. This Administrative R met as evidenced by: Based on interview an review from the 3/27/2 date of 5/1/24, the prodocumentation and/o followed for the previet to install an electricall the main entrance/exit.	ey was conducted on our compliance with the of South Dakota, Article of Centers, requirements for es cited on 3/27/24. Ir Living - Fort Pierre was ce with the following S296, S990, S680 and soant Protection ally activated audible alarm, ections of this article, on any Any other exterior door rmed. The alarm must be ed staff station and may not if the door is closed; ule of South Dakota is not and plan of correction (POC) 24 survey with a completion ovider failed to provide revidence that the POC was ously cited deficiency S169 by activated audible alarm for it. Findings include: inistrator A on 5/28/24 at an acceptable solution for	{S 000}	We will have a read in read or access on the front door that a approved residents and staff of operate after hours. We will all have a door pressure sensor of breakaway function of the door is tied to an alarm near the nustation. This alarm if tripped, where the door are is reviewed by staff to ensure event is safe for all residents a staff. Tech involved: RFID real either side of the door, Pressure sensor in the door, door sensor alarm at nurse's station. Equipplies on order, awaiting electricial install. Once door alarm is insistaff will audit for 12 months (February 2025). Maintenance designee will audit weekly for compliance. Results will be shat QAPI meeting. Administrated designee will notify DOH if contractor cannot meet the da 7/1/24	all can so on the or, that rses' vould fter it the and der on or oment n talled, thru or alarm ared or or	07/01/20 24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Heather Janes , Administrator, 06/04/2024

TITLE

(X6) DATE

South Dakota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		80072	B. WING		ANDRES	8/2024
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA			
PEACEFU	L PINES SENIOR LIVING	G - FORT PIERRE	OWSTONE ST RRE, SD 57532			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{S 296}	Continued From page	1	{S 296}			
{S 296}	44:70:04:04(1-11) Pe	rsonnel Training	{S 296}	Personnel Training (EduCare) h		06/24/
	days of hire for all her include the following so include the following so (1) Fire prevention at (2) Emergency process including responding and information regar (3) Infection control at (4) Accident prevention (5) Resident rights; (6) Confidentiality of (7) Incidents and discreporting and the faci (8) Nutritional risks at residents; (9) Abuse and neglect (10) Problem solving techniques related to impairment or challent and retained in the faci (11) Any additional heducation necessary resident care needs personnel to the residented in the facility.	and response; dures and preparedness, to resident emergencies ding advanced directives; and prevention; on and safety procedures; resident information; eases subject to mandatory lity's reporting mechanisms; and hydration needs of ct; and communication individuals with cognitive leging behaviors if admitted cility; and ealthcare personnel based on the individualized brovided by the healthcare dents who are accepted and the facility determines will residents are exempt from		been completed by Employees R, S completed by the deadline given (June 24, 2024). Transcri are complete and available through EduCare. Results will be shared QAPI meetings. Administrator of designee will continue to audit through February 2025.	pts ugh d at	2024
	This Administrative R	ule of South Dakota is not				

PRINTED: 05/31/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING 80072 05/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {S 296} Continued From page 2 {S 296} met as evidenced by: Based on interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 4/30/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S296 for having failed to ensure the required employee training was completed for employees L, Q, R, and S. Findings include: 1. Review of the provider's POC revealed: "All staff were given a timeline of April 30, 2024, to complete their required 30-day training. The hospice care and abuse, neglect, and misappropriation of resident property and funds training was assigned to every staff member with a timeline of April 30, 2024, to complete." Interview with administrative assistant T and review of the ongoing "Courses to Complete" audit on 5/20/24 at 9:15 a.m. revealed the following: *Employee L was hired on 11/14/23. *Employee Q was hired on 3/19/24. *Employee R was hired on 12/18/23. *Employee S was hired on 11/9/23. *The the required 30-day training had not been completed for: -Employee L, R, and S regarding abuse, neglect, and misappropriation of resident funds. -Employee L, Q, R, and S regarding the individualized care needs of residents.

disease reporting.

preparedness.

-Employees Q and R regarding incident and

-Employee Q regarding emergency

Interview on 5/20/24 at 8:55 a.m. with administrator A regarding the required 30-day

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
80072			B. WING			-C 28/2024	
NAME OF P	ROVIDER OR SUPPLIER	s	TREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	1 03/	20/2024
PEACEFU	IL PINES SENIOR LIVING	- FORT PIERRE		WSTONE ST			,
(VA) ID	SI IMMADY ST	ATEMENT OF DEFICIENCIES	ORT PIERR	E, SD 57532			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION OF	BE	(X5) COMPLETE DATE
{S 296}	Continued From page	3		{S 296}			
	employeesEmployees L, Q, R, a their training.	Itiple email reminders to a and S had not completed OC from the 3/27/24 surv	all		Weekly audits for medication e are conducted by DON or desi to ensure reporting and		07/01/20 24
{S 680}	{S 680} 44:70:07:08 Medication Records And Administration A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication.			{S 680}	documentation of each medical error are documented correctly policy and procedure. Reviewed weekly for 8 weeks, then mont 3 thru October 31, 2024. Results will be shared at QAPI meetings. DON re-educated A and PRN nurses via e-mail 05/23/2024 policy and procedured on medication errors. Follow-uprovided with each nurse by D Results will be shared at QAPI meetings.	ly per red thly for ults of ADON ures up was DON.	
	met as evidenced by: Based on interview an review from the 3/27/2 date of 4/30/24, the pr documentation and/or followed for the previo "The DON [director of conduct weekly audits [medication administra no medication errors h Interview and review of on 5/20/24 at 10:10 a.)	ation records] to ensure the nave been made." of medication error reports	c) on vas o iiii				

PRINTED: 05/31/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C 80072 05/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {S 680} Continued From page 4 {S 680} two medication errors for resident 9 revealed: *Review of two medication error reports dated 5/13/24 at 11:32 a.m. and again on 5/13/24 with a p.m. time circled and no other time details recorded revealed CNA/UMA H had "misread the instructions and gave two tabs [tablets] at noon dose." -The care provided included "Resident received more than prescribed [dose], but not over daily allowance". -The "Reason for Errors" area had "Wrong dose" and "Misread order" marked. -The resident's physician was not notified of these medication errors. *DON C and ADON U had not thought the physician needed notification, as the total amount given was not over the daily allowance for that medication for resident 9. Continued interview on 5/20/24 at 11:37 a.m. DON C regarding medication errors for resident 9

STATE FORM

-"Notification of provider".

revealed she:

ordered.

must include:"

medical record."

*Thought it was at the nurse's discretion to notify a physician for acetaminophen medication errors. *Confirmed resident 9's acetaminophen order had been physician prescribed and not given as

*She confirmed the POC for the 3/27/24 revisit

Review of the provider's 8/1/22 Medication and Treatment Orders policy revealed the following: *"If medications assistance and/or administration was not completed as prescribed, documentation

*"Medication errors will be reported to the licensed nurse, Administrator, and resident's provider, and an entry made in the resident's

survey had not been implemented.

NAME OF PROVIDER OR SUPPLIER PEACEFUL PINES SENIOR LIVING - FORT PIERRE SUMMARY STATEMENT OF DEFICIENCIES 1000 YELLOWSTONE STREET PORT PIERRE, S. 0 37532			IDENTIFICATION NUMBER:	A. BUILDING:	(X3) DATE SURVEY COMPLETED						
NAME OF PROVIDER OR SUPPLIER PEACEFUL PINES SENIOR LIVING - FORT PIERRE (CA) ID PREFIX INDIGENCY MUST BE PRECEDED BY FULL TAG (CA) ID PREFIX INDIGENCY MUST BE PRECEDED BY FULL TAG (CA) ID PREFIX INDIGENCY MUST BE PRECEDED BY FULL TAG (CA) ID PREFIX INDIGENCY MUST BE PRECEDED BY FULL TAG (CA) ID PREFIX INDIGENCY MUST BE PRECEDED BY FULL TAG (CA) ID PREFIX TAG (CA) ID PROFIX TAG (CA) ID PREFIX TA						R-C	;				
PEACEFUL PINES SENIOR LIVING - FORT PIERRE (A4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL. REGULATORY OR ISC IDENTIFYING INFORMATION) TAG (S 990) 44:70:10:21(1) Ventilating Systems The ventilating systems must maintain temperatures, minimum air changes of outdoor air per hour, minimum total air changes, and relative humidities as follows: (1) For all occupied areas, the facility shall be able to maintain a minimum temperature of seventy-five degrees Fahrenheit or 23.9 degrees centigrade at winter design conditions with a minimum of at least two total air changes per hour. Each air supply and air exhaust system must be mechanically operated. Any outdoor ventilation air intake, other than for an individual room unit, must be located as far away as practicable but not less than twenty-five feet or 7.82 meters from any yeultaing system or combustion equipment. The bottom of any outdoor intake serving a central air system must be located as high as possible but not less than three feet or 0.91 meters above the ground level. Each mechanical ventilation system must be designed and balanced to provide make-up air and safe pressure relationships between adjacent areas to preclude the spread of infections and assure the health of the occupants. Each room supply air lieft, reforculation infect, and exhaust air outtet must be located with the grill or diffuser opening not less than three inches or 0.08 meters above the floor. A corridor may be used to ventilate a bathroom, a tollet room, or a janitor's closet opening directly not be corridor. Mechanical			80072	B. WING		05/28	/2024				
(X-9) ID SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY OR LSS IDENTIFYING INFORMATION) (S-990) (S-99	NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODE						
PREFIX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (S 990) 44:70:10:21(1) Ventilating Systems The ventilating systems must maintain temperatures, minimum air changes of outdoor air per hour, minimum total air changes, and relative humidities as follows: (1) For all occupied areas, the facility shall be able to maintain a minimum temperature of seventy-five degrees Fahrenheit or 23,9 degrees centigrade at winter design conditions with a minimum of at least two total air changes per hour. Each air supply and air exhaust system must be mechanically operated. Any outdoor ventilation air intake, other than for an individual room unit, must be located as far away as practicable but not less than twenty-five feet or 7.62 meters from any ventilating system or combustion equipment. The bottom of any outdoor intake serving a central air system must be located as high as possible but not less than three feet or 0.91 meters above the ground level. Each mechanical ventilation system must be designed and balanced to provide make-up air and safe pressure relationships between adjacent areas to preclude the spread of infections and assure the health of the occupants. Each room supply air inlet, recirculation inlet, and exhaust air outlet must be located with the grill or diffuser opening not less than three inches or 0.08 meters above the floor. A corridor may not be used to supply air for or exhaust air from any room, except that air from a corridor may be used to ventilate a bathroom, a toilet room, or a janitor's closet opening directly on the corridor. Mechanical	PEACEFU	PEACEFUL PINES SENIOR LIVING - FORT PIERRE									
The ventilating systems must maintain temperatures, minimum air changes of outdoor air per hour, minimum total air changes, and relative humidities as follows: (1) For all occupied areas, the facility shall be able to maintain a minimum temperature of seventy-five degrees Fahrenheit or 23.9 degrees centigrade at winter design conditions with a minimum of at least two total air changes per hour. Each air supply and air exhaust system must be mechanically operated. Any outdoor ventilation air intake, other than for an individual room unit, must be located as far away as practicable but not less than therefy-five feet or 7.62 meters from any plumbing vent stack and the exhaust from any ventilating system or combustion equipment. The bottom of any outdoor intake serving a central air system must be located as high as possible but not less than three feet or 0.91 meters above the ground level. Each mechanical ventilation system must be designed and balanced to provide make-up air and safe pressure relationships between adjacent areas to preclude the spread of infections and assure the health of the occupants. Each room supply air inlet, recirculation inlet, and exhaust air outlet must be located with the grill or diffuser opening not less than three inches or 0.08 meters above the floor. A corridor may not be used to supply air to or exhaust air from any room, except that air from a corridor may be used to ventilate a bathroom, a toilet room, or a janitor's closet opening directly on the corridor. Mechanical	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE				
areas, wet areas, toilet rooms, and clean storage rooms. In any unoccupied service area, ventilation may be reduced or discontinued if the		The ventilating system temperatures, minimulair per hour, minimum relative humidities as able to maintain a min seventy-five degrees in centigrade at winter dominimum of at least two hour. Each air supply must be mechanically ventilation air intake, or croom unit, must be located but not les 7.62 meters from any the exhaust from a corridor opening of less than above the floor. A corrispuly air to or exhaust hat air from a corridor bathroom, a toilet room opening directly on the exhaust ventilation mulareas, wet areas, toilet rooms. In any unoccup	as must maintain m air changes of outdoor total air changes, and follows: reas, the facility shall be imum temperature of Fahrenheit or 23.9 degrees esign conditions with a vo total air changes per and air exhaust system operated. Any outdoor other than for an individual sated as far away as as than twenty-five feet or plumbing vent stack and ventilating system or t. The bottom of any a central air system must possible but not less than ters above the ground level. It is illation system must be do to provide make-up air tionships between adjacent spread of infections and e occupants. Each room lation inlet, and exhaust air with the grill or diffuser three inches or 0.08 meters idor may not be used to set air from any room, except may be used to ventilate a not or a janitor's closet to corridor. Mechanical st be provided in all soiled to rooms, and clean storage of the service area,	{S 990}							

FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C 80072 B. WING 05/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {S 990} Continued From page 6 {S 990} health and comfort of the occupants are not compromised; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) 07/01/ review from the 3/27/24 survey with a completion Facility has confirmed that Electrician 2024 date of 5/10/24, the provider failed to provide has not provided a timeline for documentation and/or evidence that the POC was installation completion. Administrator followed for the previously cited deficiency S990 and Director of Maintenance are in to install exhaust ventilation for three of three contact and will let DOH know when storage rooms and one laundry room. Findings updates are available regarding include: timeline. Will continue to be in contact with vendor. Administrator or 1. Interview with the administrator A on 5/28/24 at 11:25 a.m. revealed the contractor had not designee will notify DOH if contractor completed the necessary wiring for the exhaust cannot meet the date of 7/1/24 fan ventilation installations. {S1039} 44:70:10:32 Electrical Distribution System {S1039} A facility with 17 beds or larger shall be equipped with an emergency electrical service that includes an automatic generator set and automatic transfer switches serving emergency panels. A facility with 17 beds or larger shall have automatic emergency lighting for each exit way, staff work areas, dining room, medication room, dietary department, medication room, room where main entrance electrical panels are located, boiler room, and exterior lighting serving required exits. A facility with 17 beds or larger shall have automatic emergency power for the fire alarm

system, electrical receptacle servicing computers containing resident care records, telephone system, door alarms, and staff call system.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY						
DENTI IDANION NOMBER.		A. BUILDING:		COMPLETED						
80072		B. WING		R-C 05/28/2024						
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE						
PEACEFU	PEACEFUL PINES SENIOR LIVING - FORT PIERRE 1000 YELLOWSTONE STREET									
		FORT PIE	RRE, SD 5753	2						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE					
{S1039}	Continued From page	7	{S1039}							
	This Administrative Rumet as evidenced by: Based on interview ar review from the 3/27/2 date of 5/10/24, the prodocumentation and/or followed for the previous	and plan of correction (POC) 24 survey with a completion revider failed to provide revidence that the POC was pusly cited deficiency S1039 annunciator in a 24-hour		Facility confirmed timeline with Electrician, wiring to be connect and parts to be received and delivered. Administrator and Dir of Maintenance to continue communication with Electrician.	ector 024					
	11:25 a.m. revealed th	ary wiring for the generator								

(X3) DATE SURVEY

South Dakota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
80072 B.		B. WNG	B. WING		R-C 05/28/2024	
	ROVIDER OR SUPPLIER	G - FORT PIERRE 1000 YELL	ORESS, CITY, STA	REET		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
	Administrative Rules 44:70, Assisted Living all previous deficienci Peaceful Pines Senio found not in complian requirements: S169, S1039. 44:70:02:17(5) Occup The facility shall: (5) Install an electrical if required by other sequired by other sequired by other sequinattended exit door, must be locked or ala audible at a designate automatically silence. This Administrative R met as evidenced by: Based on interview all review from the 3/27/2 date of 5/1/24, the prodocumentation and/ofollowed for the preview to install an electrical the main entrance/ex.	ey was conducted on for compliance with the of South Dakota, Article of Centers, requirements for es cited on 3/27/24. In Living - Fort Pierre was ce with the following S296, S990, S680 and soant Protection ally activated audible alarm, ections of this article, on any Any other exterior door remed. The alarm must be ed staff station and may not if the door is closed; ulle of South Dakota is not and plan of correction (POC) 24 survey with a completion envider failed to provide revidence that the POC was pusly cited deficiency S169 by activated audible alarm for it. Findings include: inistrator A on 5/28/24 at an acceptable solution for	{S 000}	We will have a read in read out access on the front door that a approved residents and staff operate after hours. We will all have a door pressure sensor of breakaway function of the door is tied to an alarm near the nurstation. This alarm if tripped, where the door all is reviewed by staff to ensure event is safe for all residents a staff. Tech involved: RFID real either side of the door, Pressure sensor in the door, door sensor alarm at nurse's station. Equippis on order, awaiting electricial install. Once door alarm is instaff will audit for 12 months (February 2025). Maintenance designee will audit weekly for compliance. Results will be shat QAPI meeting. Administrated designee will notify DOH if contractor cannot meet the da 7/11/24	all san so on the r, that rses' vould fter it the and der on re or ment n talled, thru or alarm ared or or	07/01/20 24

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Heather Janes , Administrator, 06/04/2024

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED				
	80072		B. WING		R-0	C B/2024		
		00072				05/20	0/2024	
NAME OF PE	ROVIDER OR SUPPLIER			RESS, CITY, STA				
PEACEFU	PEACEFUL PINES SENIOR LIVING - FORT PIERRE 1000 YELLOWSTONE STREET FORT PIERRE, SD 57532							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
{S 296}	Continued From page	2 1		{S 296}				
	These programs must days of hire for all heat include the following state (1) Fire prevention at (2) Emergency procest including responding and information regar (3) Infection control at (4) Accident preventi (5) Resident rights; (6) Confidentiality of (7) Incidents and discreporting and the faci (8) Nutritional risks at residents; (9) Abuse and neglect (10) Problem solving techniques related to impairment or challer and retained in the faci (11) Any additional heducation necessary resident care needs part (2) includes the faci (11) Any additional heducation necessary resident care needs part (2) includes the faci (3) includes the faci (4) includes the faci (5) includes the faci (6) includes the faci (7) includes the faci (11) Any additional heducation necessary resident care needs part (6) includes the faci (6) includes the faci (7) includes the faci (7) includes the faci (8) includes the faci (8) includes the faci (9) includes the faci (10) includes the faci (11) includes the faci (12) includes the faci (13) includes the faci (14) includes the faci (15) includes the faci (15) includes the faci (16) includes	t be completed within althcare personnel and subjects: and response; adures and prepared not oresident emergence and prevention; on and safety proced aresident information; eases subject to manulity's reporting mechand hydration needs of the communication and communication individuals with cogning behaviors if admicility; and ealthcare personnel based on the individual crovided by the health dents who are accepted. The facility determine residents are exempted.	d must less, lies lives; lures; datory nisms; f litive nitted ualized ncare led and les will	{S 296}	Personnel Training (EduCare) been completed by Employees R, S completed by the deadline given (June 24, 2024). Transcriare complete and available through EduCare. Results will be share QAPI meetings. Administrator of designee will continue to audit through February 2025.	L, Q, ipts ough d at	06/24/2024	
	This Administrative R	ule of South Dakota	is not					

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disease reporting.

preparedness.

-Employee L, Q, R, and S regarding the individualized care needs of residents. -Employees Q and R regarding incident and

-Employee Q regarding emergency

Interview on 5/20/24 at 8:55 a.m. with administrator A regarding the required 30-day

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _	The state of the s				
	80072		B. WNG		R-C 05/28/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PEACEFU	L PINES SENIOR LIVING	G - FORT PIERRE	OWSTONE ST				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
{S 296}	Continued From page	3	{S 296}				
	employeesEmployees L, Q, R, a their training.	and S had not completed all OC from the 3/27/24 survey		Weekly audits for medication e are conducted by DON or desi to ensure reporting and	gnee	07/01/20 24	
{S 680}	{S 680} 44:70:07:08 Medication Records And Administration A facility shall establish and implement written policies and procedures to check the resident's medication administration records against the physician, physician assistant, or nurse practitioner's orders to verify accuracy. Each medication administered must be recorded in the resident's care record and signed by the individual administering the medication.		{S 680}	documentation of each medical error are documented correctly policy and procedure. Reviewed weekly for 8 weeks, then mont 3 thru October 31, 2024. Resulandits will be shared at QAPI meetings. DON re-educated A and PRN nurses via e-mail 05/23/2024 policy and procedure on medication errors. Follow-uprovided with each nurse by D Results will be shared at QAPI meetings.	/ per ed hly for lts of DON ures p was ON.		
	met as evidenced by: Based on interview ar review from the 3/27/2 date of 4/30/24, the p documentation and/or followed for the previo "The DON [director of conduct weekly audits [medication administr no medication errors Interview and review on 5/20/24 at 10:10 a	and plan of correction (POC) 24 survey with a completion rovider failed to provide r evidence that the POC was cously cited deficiency S680 f nursing] or a designee will s on all resident MARs ation records] to ensure that have been made."					

PRINTED: 05/31/2024 FORM APPROVED South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: R-C B. WING 80072 05/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {S 680} Continued From page 4 {S 680} two medication errors for resident 9 revealed: *Review of two medication error reports dated 5/13/24 at 11:32 a.m. and again on 5/13/24 with a p.m. time circled and no other time details recorded revealed CNA/UMA H had "misread the instructions and gave two tabs [tablets] at noon -The care provided included "Resident received more than prescribed [dose], but not over daily allowance". -The "Reason for Errors" area had "Wrong dose" and "Misread order" marked. -The resident's physician was not notified of these medication errors. *DON C and ADON U had not thought the physician needed notification, as the total amount given was not over the daily allowance for that medication for resident 9. Continued interview on 5/20/24 at 11:37 a.m. DON C regarding medication errors for resident 9 revealed she: *Thought it was at the nurse's discretion to notify a physician for acetaminophen medication errors. *Confirmed resident 9's acetaminophen order had been physician prescribed and not given as ordered. *She confirmed the POC for the 3/27/24 revisit survey had not been implemented. Review of the provider's 8/1/22 Medication and

STATE FORM

-"Notification of provider".

must include:"

medical record."

Treatment Orders policy revealed the following: *"If medications assistance and/or administration was not completed as prescribed, documentation

*"Medication errors will be reported to the licensed nurse, Administrator, and resident's provider, and an entry made in the resident's

PRINTED: 05/31/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C 80072 R WING 05/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {S 990} 44:70:10:21(1) Ventilating Systems {S 990} The ventilating systems must maintain temperatures, minimum air changes of outdoor air per hour, minimum total air changes, and relative humidities as follows: (1) For all occupied areas, the facility shall be able to maintain a minimum temperature of seventy-five degrees Fahrenheit or 23.9 degrees centigrade at winter design conditions with a minimum of at least two total air changes per hour. Each air supply and air exhaust system must be mechanically operated. Any outdoor ventilation air intake, other than for an individual room unit, must be located as far away as practicable but not less than twenty-five feet or 7.62 meters from any plumbing vent stack and the exhaust from any ventilating system or combustion equipment. The bottom of any outdoor intake serving a central air system must be located as high as possible but not less than three feet or 0.91 meters above the ground level. Each mechanical ventilation system must be designed and balanced to provide make-up air and safe pressure relationships between adjacent areas to preclude the spread of infections and assure the health of the occupants. Each room supply air inlet, recirculation inlet, and exhaust air outlet must be located with the grill or diffuser

rooms. In any unoccupied service area.

ventilation may be reduced or discontinued if the

opening not less than three inches or 0.08 meters above the floor. A corridor may not be used to supply air to or exhaust air from any room, except that air from a corridor may be used to ventilate a bathroom, a toilet room, or a janitor's closet opening directly on the corridor. Mechanical exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and clean storage

South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C 80072 B. WING 05/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIERRE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {S 990} Continued From page 6 {S 990} health and comfort of the occupants are not compromised; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) 07/01/ review from the 3/27/24 survey with a completion Facility has confirmed that Electrician date of 5/10/24, the provider failed to provide 2024 has not provided a timeline for documentation and/or evidence that the POC was installation completion. Administrator followed for the previously cited deficiency S990 and Director of Maintenance are in to install exhaust ventilation for three of three contact and will let DOH know when storage rooms and one laundry room. Findings updates are available regarding include: timeline. Will continue to be in 1. Interview with the administrator A on 5/28/24 at contact with vendor. Administrator or 11:25 a.m. revealed the contractor had not designee will notify DOH if contractor completed the necessary wiring for the exhaust cannot meet the date of 7/1/24 fan ventilation installations. {S1039} 44:70:10:32 Electrical Distribution System {S1039} A facility with 17 beds or larger shall be equipped with an emergency electrical service that includes an automatic generator set and automatic transfer switches serving emergency panels. A facility with 17 beds or larger shall have automatic emergency lighting for each exit way, staff work areas, dining room, medication room, dietary department, medication room, room where main entrance electrical panels are located, boiler room, and exterior lighting serving required exits. A facility with 17 beds or larger shall have automatic emergency power for the fire alarm system, electrical receptacle servicing computers containing resident care records, telephone system, door alarms, and staff call system.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		80072	B. WING	B. WNG			
	PROVIDER OR SUPPLIER JL PINES SENIOR LIVING	G - FORT PIERRE 1000 YE	DDRESS, CITY, ST LLOWSTONE S ERRE, SD 5753	TREET	1 007	28/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
{S1039}	This Administrative Rimet as evidenced by: Based on interview ar review from the 3/27/2 date of 5/10/24, the produced for the previous to install a generator amanned location. Find 1. Interview with the a 11:25 a.m. revealed the	ule of South Dakota is not and plan of correction (POC) 24 survey with a completion rovider failed to provide evidence that the POC was busly cited deficiency S1039 annunciator in a 24-hour dings include:	{S1039}	Facility confirmed timelin Electrician, wiring to be and parts to be received delivered. Administrator of Maintenance to contin communication with Electrician electricians.	connected and and Director ue	07/01/2 024	

PRINTED: 07/24/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 80072 07/18/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 YELLOWSTONE STREET PEACEFUL PINES SENIOR LIVING - FORT PIE FORT PIERRE, SD 57532 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (S 000) Compliance Statement ${S 000}$ A second onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 7/10/24 and on /18/24 for deficiencies cited on 5/28/24. All deficiencies have been corrected, and no new noncompliance was found. Peaceful Pines Senior Living - Ft. Pierre was found in compliance.

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

TITLE

(X6) DATE