South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80072	A. BUILDING: ______ B. WING ______	C 03/27/2024

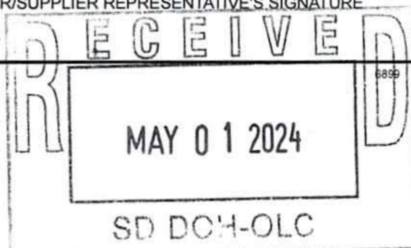
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 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 assisted living centers, was conducted from 3/26/24 through 3/27/24. The area surveyed was accidents. Peaceful Pines Senior Living-Fort Pierre was found not in compliance with the following requirement: S337.	S 000		
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were	S 130	The shared-use blood pressure cuff has been sanitized. CNA/UMA M and UMA O have been reeducated on how to sanitize medical equipment when using shared medical equipment. All other staff will be educated at an All Staff Inservice on May 7-8, 2024, to reeducate staff on this process and the infection prevention and control policy. • The DON or a designee will conduct a weekly audit of 5 random staff across all shifts to ensure that shared medical equipment is properly sanitized between uses. 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 results of these audits will be shared by the Director of Nursing or a designee at the facility's monthly QAPI meeting.	5/8/24

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

TITLE Administrator

(X6) DATE 5/1/2024



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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	**1000 YELLOWSTONE STREET FORT PIERRE, SD 57532**

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S 130	Continued From page 1 implemented for the following: *Cleaning of a shared-use blood pressure cuff by one of one certified nurse aide/unlicensed medication aide (CNA/UMA) (M) after it was used for one of one sampled resident (4). *Maintaining a sanitary environment and practicing appropriate hand hygiene by one of one UMA (O) during medication administration. Findings include: 1. Observation and interview on 3/26/24 at 3:20 p.m. with CNA/UMA M while taking resident 4's blood pressure revealed: *She removed the blood pressure cuff from the vital signs equipment cart, took the resident's blood pressure reading, then returned the blood pressure cuff to the cart without cleaning it. *The blood pressure cuff should have been sanitized before returning it to the cart. 2. Observation and interview on 3/27/24 at 6:30 a.m. with UMA O during resident 3's medication administration in her bathroom revealed: *While the resident was sitting on the toilet UMA O handed her a prepared insulin pen that she then injected into her abdomen. *After the insulin administration was completed UMA O removed her gloves, washed her hands in the resident's bathroom sink, and dried them with one of the resident's hand towels. -A paper towel dispenser hung on the wall next to the sink. *UMA O agreed a bathroom toilet was not a dignified or sanitary place for insulin administration. *Disposable paper towels should have been used to dry her hands after washing them. Interview on 3/27/24 at 2:15 p.m. with administrator A regarding infection control	S 130	UMA O was reeducated on the insulin administration policy and the sanitary locations where insulin can be administered, as well as resident dignity rights. All other staff will be reeducated at an All Staff Inservice on May 7-8, 2024, on this process and the insulin administration policy. Our Infection Control policy was provided in an email to Sarah Hendrickson on March 28, 2024. • A weekly audit of each applicable insulin-dependent resident will be conducted by the Director of Nursing or a designee, to ensure that insulin administration occurs in a sanitary setting, with staff performing proper hand hygiene, and in a dignified manner. Audits will begin on April 24, 2024, and will be conducted for 8 weeks through June 19, 2024, and continuing 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. UMA O was reeducated on the proper hand hygiene policy which includes using the single-use paper towels provided in each resident's room. All remaining staff will be reeducated on this process and the hand hygiene policy at an All Staff Inservice on May 7-8, 2024.	

Heather Janes Administrator 5/1/2024

South Dakota Department of Health

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S 130	Continued From page 2 revealed: *Director of nursing C was responsible for the facility's infection control program. *Medical equipment shared by residents was expected to be cleaned after each resident's use. *Medication administration was expected to occur in a sanitary environment. *Paper towel dispensers were expected to be used after handwashing occurred the in resident rooms. Review of the 8/3/22 revised Cleaning of Shared 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 130	• The Director of Nursing or a designee will conduct a weekly audit to ensure that staff use proper hand hygiene. The audits will begin on April 24, 2024, for 8 weeks through June 19, 2024, and then continuing 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.	
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install an electrically activated audible alarm for the main entrance/exit. Findings	S 169	Our construction team (HME Care Home Office in Brookings) was reeducated on the need for an electrically-activated audible alarm for the main entrance/exit. Our construction team is researching options to implement an alarm system that meets code as specified 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. The main entrance was locked beginning on 4/24/24 and will remain locked until an approved alarm system is installed.	5/1/24

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NAME OF PROVIDER OR SUPPLIER: **PEACEFUL PINES SENIOR LIVING - FORT PIERRE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1000 YELLOWSTONE STREET FORT PIERRE, SD 57532**

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

Heather Janes Administrator 5/1/2024

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S 200	Continued From page 4 dining room). Findings include: 1. Observation on 3/25/24 at 2:35 p.m. revealed the hallway to the three independent living garages in the assisted living building had an illuminated exit sign over the locked door (into the independent living building) adjacent to garage door G103. The door was locked and could only be unlocked with a key fob. Interview with the 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 200	• If the electrical contractor cannot accommodate these updates by May 11, 2024, the Administrator or a designee will share the contractor's completion timeline with DOH by May 11, 2024. • The Administrator or a designee will notify DOH once the signs have been installed or moved as requested.	
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights;	S 296	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.	4/30/24

Heather Janes Administrator 5/1/2024

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S 296	Continued From page 5 (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). 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 property and funds training for four of five	S 296	• The Assistant Administrator or a designee will audit the course completions on May 1, 2024, and follow up with any staff members who have not completed their courses 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 conduct a weekly audit for all courses assigned, to ensure courses are 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 these audits will be shared by the Assistant Administrator or a designee at the facility's monthly QAPI meeting.	

Heather Janes Administrator 5/1/2024

South Dakota Department of Health

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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;	S 296		

Heather Janes, Administrator, 04/30/2024

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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 296		
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to ensure five of five sampled employees (C, E, H, I, and J) were evaluated by a licensed healthcare professional and determined to be free from reportable communicable diseases within fourteen days of employment. Findings include: 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.	S 305	The facility process was immediately updated to specify that for all newly-employed staff, the Communicable Disease Screening Form will be printed by the Assistant Administrator, Director of Nursing, or a designee to obtain approval and a signature from the Director of Nursing or a Registered Nurse designee. The Assistant Administrator or a designee will audit all personnel files to identify any staff whose Communicable Disease Screening Form had not been signed 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, 2024.	5/124

Heather Janes Administrator 5/1/2024

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S 305	Continued From page 8 *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. *Each employee had a Communicable Diseases Screening form in their personnel file that included the following: -A section of communicable disease screening questions answered by the employee. -A place for director of nursing (DON) C's signature acknowledging she reviewed the answers to those screening questions. *There was no process to ensure either DON C or another licensed healthcare professional had 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.	S 305	• A weekly audit will be conducted by the Director of Nursing or a designee to ensure that the Communicable Disease Screening Forms are signed by the Director of Nursing or a Registered Nurse. These audits will begin on April 24, 2024, for 8 weeks through June 19, 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.	
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on the South Dakota Department of Health	S 337	An All Staff Inservice will be held on May 7-8, 2024, to reeducate staff on the following policies: 1. Fall Prevention and Response policy, which includes the process for monitoring vitals after a fall. 2. Insulin Administration policy, including the appropriate delegation to UMAs versus UDAs. 3. Self-Administration policy and the Nebulizer/Inhaler Treatment Administration policy.	5/8/24

Heather Janes, Administrator 5/1/2024

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S 337	Continued From page 9 (SD DOH) event report reviews, record review, interview, and policy review, the provider failed to ensure: *The provider's policy and fall checklist procedure for fall response was followed for two of three sampled residents (5 and 7) who had head injuries as a result of their falls. *One of one unlicensed medication aide (UMA) (O) correctly prepared an insulin pen for administration by one of one insulin dependent sampled resident (3). *One of one UMA (O) who dialed the insulin dose for one of one sampled resident's (3) insulin administration received unlicensed diabetic aide (UDA) training. *One of one certified nurse aide(CNA)/UMA (L) demonstrated correct inhaler administration for one of one sampled resident (4). Findings include: 1.Review of the provider's SD DOH event report for resident 7 indicated on 2/10/24 he had two falls. The first fall occurred at 9:30 a.m. The second fall occurred at 11:30 a.m. a. At 9:30 a.m. resident 7 and his friend went to 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." *No investigation was completed for the 9:30 a.m. fall. *After the haircut, resident 7's friend took him to his room. -She left him in his recliner for a nap. *UMA H stated it had been an hour or so before	S 337	• A weekly audit will be conducted by the Director of Nursing or a designee to ensure staff compliance with policies 1, 2, and 3 listed above. These audits will begin on May 1, 2024, for 8 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. • A weekly audit will be conducted by the Director of Nursing or a designee to ensure that all falls are documented according to the fall checklist and procedure, and that the procedure was followed accordingly. These audits will begin on May 1, 2024, for 8 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.	

Heather Janes, Administrator, 5/1/2024

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S 337	Continued From page 10	S 337		

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

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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

(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
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revealed:
*UMA H found resident 7 between the bed and the wall.
*She called 911 then called on-call RN G.
*His vital signs and neuros had not been checked until the ambulance had arrived.

Phone interview on 3/27/24 with RN G regarding resident 7's falls on 2/10/24 revealed:
*She had not received a phone call regarding his 9:30 a.m. fall, but she should have been notified at the time.
*She was called in for the 11:30 a.m. fall.
*She did not get the call until after they called 911.
-The ambulance arrived before her.
*She had not known about the 9:30 a.m. fall until the ambulance was on their way to the emergency room following the second fall.
*She confirmed the provider's fall policy and the fall checklist had not been followed.

2. Review of the provider's SD DOH event report for resident 5 indicated on 3/3/24 at 7:35 p.m.
*UMA E and RCA D heard a crash and found resident 5 on the floor in front of her chair, curled up with her head near the wall.
*Resident 5 had a bleeding laceration on her head.
*UMA E applied a towel and pressure to her head to stop the bleeding.
*RCA D left the room to get medical supplies and to call 911.
*UMA E remained with resident 5 and talked.
*Once the ambulance arrived, the crew checked vital signs and neuros.

Review and interview on 3/27/24 at 1:00 p.m. with administrator A regarding resident 5's Fall Checklist revealed:
*The vital signs had not been obtained by UMA E

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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 nurse. -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 documented in the progress notes.	S 337		

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S 337	Continued From page 13 *A nurse would review the service plan and update it as appropriate. Review of the Fall Checklist revealed: *Ask the resident if he/she is alright. *Ask the resident if he/she hit their head, and check for bumps and bruising, or bleeding. *Obtain vital signs before getting the resident up. *If vitals are out of parameters or the resident hit their head, or if the resident is on blood thinners, call the on-call nurse at the time of the fall. *Call 911 if the resident has obvious signs of injuries that may require emergency attention. *If the resident is unable to get up independently, call the nurse to report the resident's fall, vital signs, and symptoms of injury or pain. *Call the family and physician.	S 337		

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	3. Observation and interview on 3/27/24 at 6:45 a.m. with UMA O preparing resident 3's insulin pen for self-administration revealed she: *Attached the needle onto the end of the insulin pen without first cleaning the top of that pen. -Knew the top of the pen was should have been cleaned with an alcohol pad before attaching the needle. *Failed to prime the pen before dialing the correct number of insulin units to be administered. -It was not her usual practice to prime the pen before dialing the correct insulin. *Was not a UDA. 4. Observation and interview on 3/27/24 at 9:15 a.m. with CNA/UMA L during and following resident 4's inhaler self-administration revealed: *The resident appropriately inhaled two puffs from the inhaler. *Without first instructing the resident to rinse her mouth out after using the inhaler, CNA/UMA L gave the resident a cup of Juven (promotes wound healing) powder mixed with water that the resident drank. *The budesonide/formoterol inhaler label instructions read: "Rinse mouth after use." -CNA/UMA L knew she should have had the resident rinse her mouth out with water after using the inhaler but "she [the resident] sometimes refuses". Interview on 3/27/24 at 7:45 a.m. with administrator A revealed:		UMA O will complete UDA training before assisting with administration of insulin. The Director of Nursing will reeducate UMA O on the facility's insulin administration policy, including proper cleaning, priming, and insulin administration practices. The Director of Nurisng will shadow UMA O for 1 week to ensure proper practices and responsibilities are maintained with no issues. Additional UDA training will be provided for eligible UMAs as determined by the Director of Nursing. The DON will ensure that UDA training is completed before these UMAs administer any insulin to residents. The Director of Nursing has reeducated CMA/UMA L on proper self-administration of inhalers, and she or a designee will conduct a weekly audit of 5 random inhaler administrations to ensure the proper administration technique was followed. These audits will begin on May 1, 2024, for 8 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 DON or a designee at the facility's monthly QAPI meeting.	5/11/24

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S 337	Continued From page 15 *UMA O had not followed the facility's policy for insulin administration which included proper cleaning and priming of the insulin pen. *Tasks associated with resident 3's insulin preparation and administration were not 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. 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 to dry" before attaching the need on the end of the insulin pen. -"Prime needle by dialing pen to 2 units and pushing the plunger until a small drop or stream of insulin is seen." 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." Review of the undated Inhaler Skills Checklist revealed "15. For steroid inhalers, provide resident with a cup of water and instruct to rinse mouth and spit water back into cup" after inhaler medication administration.	S 337		
S 468	44:70:06:06 Therapeutic Diets	S 468	The facility has signed a contractual agreement with a Registered Dietician, who will begin working with staff immediately. Together with the Registered Dietician and Director of Nursing, the Dietary Manager will audit resident physician orders to identify all residents with a prescribed therapeutic diet.	5/11/24

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S 468	Continued From page 16 A facility that admits or retains any resident requiring a therapeutic diet, excluding low sodium diets, shall employ or contract with a dietitian. The dietitian shall approve written menus and diet extensions, assess the resident's nutritional status and dietary needs, plan individual diets, 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 on 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.	S 468	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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*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 therapeutic diets ordered.
-They were served the same regular diets as all of the other residents.
*The facility used an agency called "Dining RD" [registered dietician] that only reviewed and signed off on their regular diet menus.

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

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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."	S 468		

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S 503	44:70:06:16(1-3) Person In Charge Of Dietary Services The person in charge of dietary services shall possess a current certificate from: (1) A ServSafe Food Protection Course; (2) The Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association; or (3) Equivalent training as determined by the department. 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 dietary manager and at least one employed cook had completed and possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 3/26/24 at 11:15 a.m. with head chef B in the kitchen revealed: *He managed the dietary department. *He and cook P possessed current, required ServSafe certificates. Review of head chef B and cook P's personnel files and interview on 3/27/24 at 7:30 a.m. with administrator A revealed Head chef B and cook P had current ServSafe Food Handling Program certificates not ServSafe Food Protection Program certificates. Review of the 8/1/22 revised Dietary Department	S 503	Two staff members from the facility will take the required ServSafe Food Protection Course titled, "ServSafe Manager Course," which meets the requirements of 44:70:06:16(1-3). Courses will begin no later than May 1, 2024, to be completed by May 10, 2024. • The Assistant Administrator or a designee will audit the ServSafe course completions on May 11, 2024, and follow up if the two designated team members 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.	5/10/24

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S 503	Continued From page 20 policy revealed "1. The Dietary Department is managed by a staff member who is certified from a ServSafe Food Protection Course, the Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association, or equivalent training determined by the SD [South Dakota] Department of Health."	S 503		
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to ensure required dietary inservice training (food safety, handwashing, food handling/preparation techniques, food-borne illness, serving 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 these audits will be shared by the Assistant Administrator or a designee at the facility's monthly QAPI meeting.	4/30/24

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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. *"The training shall be provided to any dietary or food-handling employee within 30 days of hire and annually."	S 506		
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	S 633	The Director of Nursing has 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 on May 7-8, 2024.	5/8/24

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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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S 633	Continued From page 22 used, the medication name and strength, expiration date, and a control number must be on the unit dose packet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *One of one sampled resident's (3) insulin pen was dated when it was opened or had a use by date according to the manufacturers' instructions. *One of one sampled resident's (4) inhaler was labeled with a date when it was opened. Findings include: 1. Observation and interview on 3/27/24 at 6:30 a.m. with unlicensed medication aide (UMA) O while she was preparing resident 3's morning medication pass revealed: *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	S 633	The Director of Nursing or a designee will audit all insulin pens, inhalers, and bottled/contained medications to ensure the presence 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 QAPI meeting in May 2024. • The Director of Nursing or a designee will audit all insulin pens, inhalers, and bottled/contained medications to ensure the presence of "opened" or "expires" dates. These weekly 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 these audits will be shared by the Director of Nursing or a designee at the facility's monthly QAPI meeting.	

Heather Janes, Administrator, 5/1/2024

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S 633	Continued From page 23 administrator A regarding medication labeling revealed: *Director of nursing C was responsible for ensuring medications were properly labeled with opened and expiration dates when those medications were checked into the facility. *UMAs were responsible for notifying DON C if medications were not appropriately labeled. *Resident 3's insulin pen and resident 4's inhaler were not properly labeled. Review of the 8/1/22 Security and Accountability of Medications policy revealed "5. Prescription drugs will be kept in the original container dispensed by the pharmacy bearing the original prescription label with legible information including resident name, physician name, name of drug and strength, directions for use, prescription date, and expiration date."	S 633		
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. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to ensure	S 680	The Director of Nursing has reeducated CNAs/UMAs L and E on the Medication Records and Administration policy and procedure, which includes the process to document medication errors and the protocol to administer nebulizer treatments, specifically Resident 2's nebulizer orders. All other staff will be reeducated at an All-Staff Inservice training on May 7-8, 2024. The Director of Nursing has notified the resident's provider about the medication error. • The DON or a designee will conduct weekly audits on all resident MARs to ensure that no medication errors have been made. 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 these audits will be shared by the Assistant Administrator or a designee at the facility's monthly QAPI meeting.	5/8/24

Heather Janes Administrator 5/1/2024

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S 680	Continued From page 24 two of two certified nurse aides/unlicensed medication aides (CNA/UMAs) (L and E) had not documented a nebulizer treatment was administered for one of one sampled resident (2) when the nebulizer medication was not available. Findings include: 1. Review of resident 2's March 2024 Medication Administration Record (MAR) and interview on 3/26/24 at 4:10 p.m. with CNA/CMA E at the medication cart revealed: *Resident 2 had two nebulizer treatment orders: -Budesonide. "Inhale 1 vial via neb [nebulizer] two times daily" (AM and PM). -Ipratropium/albuterol. "Inhale 1 vial via neb four times daily"(AM, noon, PM, and evening). *The ipratropium/albuterol nebulizer vials were stored in the medication cart. -CNA/CMA E was told by CNA/CMA L the budesonide vials were stored in the resident's room. Continued observation and interview with CNA/CMA E and resident 2 in his room revealed: *CNA/CMA E set up and started the resident's scheduled PM ipratropium/albuterol nebulizer treatment. *There were no vials of the budesonide in the resident's room so the scheduled PM budesonide nebulizer treatment was not administered. *Resident 2 was aware of only one nebulizer medication he was scheduled to take and he stored no nebulizer vials in his room. -He kept an Albuterol inhaler on his bedside table. *CNA/CMA E documented on resident 2's MAR the PM budesonide nebulizer was not administered because the medication was not available. *She documented on the MAR his 3/26/24 AM budesonide nebulizer treatment was	S 680		

Heather Janes Administrator 5/1/2024

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S 680	Continued From page 25	S 680		

administered.
-Confirmed the medication was not administered.
*She had not reported to anyone the medication was unavailable.

2. Review of resident 2's March 2024 MAR and interview on 3/27/24 at 9:20 a.m. with CNA/CMA L regarding the storage of resident 2's budesonide vials in his room revealed:
*She referred to the Albuterol inhaler stored on the resident's bedside table as his budesonide.
*After comparing the label on the Albuterol inhaler to the resident's MAR she agreed the Albuterol inhaler and the budesonide nebulizer vial were not the same medication.
*On 3/25/24 she documented on the resident MAR his AM and PM budesonide nebulizer treatments were administered and they were not.
*That was a medication error.

Review of the undated Medication Administration and 6 Rights CMA skills checklist revealed the following expectations for medication administration:
1. Medications must be administered according to the prescriber's orders at all times.
2. Always know what medications are being administered.
3. Call the nurse with any medication or medication order questions.
5. Check the MAR order against the medication label three times prior to administering medication to verify the right medication and the right medication route is followed.

Review of the 8/1/22 Medication and Treatment Orders policy revealed:
*"7. If medication assistance and/or administration was not completed as prescribed, documentation must include:

Heather Janes Administrator 5/1/2024

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S 680	Continued From page 26 a. Reason b. Follow up procedures, which may include notification of pharmacy, notification of nurse, notofication of provider. 8. Medication errors will be reported to the licensed nurse, administrator, and resident's provider, and an entry made in the resident's medical record."	S 680	The Director of Nursing has reeducated CNA/UMA E, UMA O, and CNA/UMA L on the proper protocol for Self-Administration of Medications. All other staff will be reeducated at an All-Staff Training session on May 7-8, 2024. By 5/20/34, the DON will complete self-administration audits for residents 2, 3, and 4 to determine ability to self-administer medications.	5/8/24
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to ensure residents were assessed to self-administer medications safely for: *One of one sampled resident (2) who self-administered a nebulizer treatment.	S 685	The Director of Nursing will audit all resident charts to identify (1) those whose physicians have approved self-administration of medications have been appropriately assessed and are administering medications according to facility policy, and (2) those whose physicians have denied the ability to self-administer medications are not self-administering medications as prescribed. The Director of Nursing will update these resident care plans accordingly. This will all be completed no later than April 30, 2024. • The Director of Nursing or a designee will audit all resident MARs to ensure that self-administration of medications is carried out in accordance with provider orders and the facility's Self-Administration of Medications policy. 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 these audits will be shared by the Director of Nursing or a designee at the facility's monthly QAPI meeting.	

Heather Janes Administrator 5/1/2024

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S 685	Continued From page 27 *One of one sampled resident (3) who self-administered insulin. *One of one sampled resident (4) who self-administered an inhaler. Findings include: 1. Interview and review of the facility's 12/20/23 provisional license during the entrance conference interview on 3/26/24 at 11:30 a.m. with administrator A revealed: *The facility accepted residents for admission who self-administered their medications. -There were no current residents who self-administered their medications. 2. Observation on 3/26/24 at 4:10 p.m. of certified nurse aide (CNA)/unlicensed medication aide (UMA) E during administration of resident 2's nebulizer treatment in his room revealed she: *Opened a vial containing budesonide nebulizer solution, poured it into the medication cup on the nebulizer mouthpiece, and closed the cup. -Handed the nebulizer mouthpiece to the resident and turned on the nebulizer machine to start the resident's treatment. *Left the room and the resident to complete the treatment on his own. Review of resident 2's electronic medical record (EMR) revealed his: *Admission date was 3/11/24. *Physician Admission Orders-AL (Assisted Living) signed on 3/8/24 indicated he was able to self-administer medications. *Medication self-administration assessment completed on 3/13/24 indicated: -"Resident needs assistance with dosage, timing etc. Able to know when to administer PRN [as needed] Albuterol, will receive provider order to keep in room, all other medications will be kept in	S 685		

Heather Janes Administrator 5/1/2024

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S 685	Continued From page 28 medcart [medication cart] and administered by medaids [UMAs] or RN [registered nurse]". *The resident's ability to safely self-administer his nebulizer treatment was not assessed. 3. Observation and interview on 3/27/24 at 6:45 a.m. with UMA O during resident 3's insulin administration in her room revealed: *UMA O attached the needle onto the end of the insulin pen then dialed the correct dose to be administered. -Handed the insulin pen to the resident. *After injecting the insulin into her abdomen resident 3 handed the insulin pen back to UMA O. *The resident and UMA O confirmed that was the resident's usual practice of insulin administration. Review of resident 3's EMR revealed her: *Admission date was 2/12/24. *Physician Admission Orders-AL signed on 2/6/24 indicated she was not able to self-administer medications. *Medication self-administration assessment completed on 2/13/24 indicated: -"Resident is able to self-administer injections, needs assistance with timing, dosing, and correct administration of multiple medications. -IDTC (Interdisciplinary Team Committee) feels resident is safe to self-administer listed medications? "No" was marked. -Physician order: "Resident may NOT self-administer medications" was marked. 4. Observation on 3/27/24 at 9:15 a.m. of CNA/UMA L during administration of resident 4's inhaler revealed: *After shaking the inhaler CNA/UMA L handed it to the resident. -The resident administered two puffs as ordered before handing the inhaler back to CNA/UMA L.	S 685		

Heather Janes Administrator 5/1/2024

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S 685	Continued From page 29 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 ordered by physicians". *IDTC feels resident is safe to self administer listed medications? "No" was marked. *Physician order: "Resident may NOT self administer medications" was marked. 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 assessments. *Residents without a physician's order and an assessment that supported their ability to safely administer their medication should not have administered those medications. Review of the 11/4/22 Self-Administration of Medications policy revealed: *"3. Residents who wish to self-administer medications will be supervised to ensure safety. -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."	S 685		

Heather Janes Administrator 5/1/2024

South Dakota Department of Health

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S 990	Continued From page 30	S 990	The Director of Maintenance has contacted an HVAC contractor to install a fresh air supply and exhaust ventilation system in the memory care unit storage room and a mechanical exhaust ventilation system in AL 107, AL 117, and the memory care laundry room. • The Administrator or a designee will share the contractor's completion timeline for installation of these ventilation systems with DOH by May 10, 2024. • The Administrator or a designee will notify DOH once the system installations have been completed.	5/10/24
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 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 exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and clean storage rooms. In any unoccupied service area,	S 990		

Heather Janes Administrator 5/1/2024

South Dakota Department of Health

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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 care laundry room (considered a wet room) were not equipped with mechanical exhaust ventilation. 3. Interview with the administrator at the time of the observations confirmed those conditions.	S 990		
S1039	44:70:10:32 Electrical Distribution System 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	S1039	The Director of Maintenance has contacted a generator servicing contractor to install a generator enunciator in a 24-hour manned location. • The Administrator or a designee will share the contractor's completion timeline for installation of a generator enunciator with DOH by May 10, 2024. • The Administrator or a designee will notify DOH once the generator enunciator installation has been completed.	5/10/24

Heather Janes Administrator 5/1/2024

South Dakota Department of Health

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S1039	Continued From page 32	S1039		

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 status.

Interview with the administrator on 3/26/24 at 4:15 p.m. confirmed that finding.

Heather Janes, Administrator 5/1/2024

South Dakota Department of Health

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{S 000}	Compliance Statement An onsite revisit survey was conducted on 5/20/24 and 5/28/24 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 3/27/24. Peaceful Pines Senior Living - Fort Pierre was found not in compliance with the following requirements: S169, S296, S990, S680 and S1039.	{S 000}		
{S 169}	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 5/1/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S169 to install an electrically activated audible alarm for the main entrance/exit. Findings include: 1. Interview with administrator A on 5/28/24 at 11:15 a.m. revealed an acceptable solution for the door alarming issue had not yet been determined.	{S 169}	We will have a read in read out access on the front door that all approved residents and staff can operate after hours. We will also have a door pressure sensor on the breakaway function of the door, that is tied to an alarm near the nurses' station. This alarm if tripped, would need to be reset at the door after it is reviewed by staff to ensure the event is safe for all residents and staff. Tech involved: RFID reader on either side of the door, Pressure sensor in the door, door sensor alarm at nurse's station. Equipment is on order, awaiting electrician install. Once door alarm is installed, staff will audit for 12 months (thru February 2025). Maintenance or designee will audit weekly for alarm compliance. Results will be shared at QAPI meeting. Administrator or designee will notify DOH if contractor cannot meet the date of 7/1/24	07/01/2024

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

Heather Janes , Administrator, 06/04/2024

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80072	A. BUILDING: ____ B. WING ____	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

(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 296}	Continued From page 1	{S 296}		
{S 296}	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not	{S 296}	Personnel Training (EduCare) has been completed by Employees L, Q, R, S completed by the deadline given (June 24, 2024). Transcripts are complete and available through EduCare. Results will be shared at QAPI meetings. Administrator or designee will continue to audit through February 2025.	06/24/ 2024

Heather Janes, Administrator, 06/04/2024

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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{S 296}	Continued From page 2 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. -Employees Q and R regarding incident and disease reporting. -Employee Q regarding emergency preparedness. Interview on 5/20/24 at 8:55 a.m. with administrator A regarding the required 30-day	{S 296}		

Heather Janes, Administrator, 06/04/2024

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80072	A. BUILDING: ______ B. WING ______	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER: **PEACEFUL PINES SENIOR LIVING - FORT PIERRE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1000 YELLOWSTONE STREET, FORT PIERRE, SD 57532**

(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 296}	Continued From page 3 training revealed: *She had sent out multiple email reminders to all employees. -Employees L, Q, R, and S had not completed all their training. *She confirmed the POC from the 3/27/24 survey was not completed.	{S 296}		
{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. This Administrative Rule of South Dakota is not 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 S680 "The DON [director of nursing] or a designee will conduct weekly audits on all resident MARs [medication administration records] to ensure that no medication errors have been made." Interview and review of medication error reports on 5/20/24 at 10:10 a.m. with DON C and assistant director of nursing (ADON) U regarding	{S 680}	Weekly audits for medication errors are conducted by DON or designee to ensure reporting and documentation of each medication error are documented correctly per policy and procedure. Reviewed weekly for 8 weeks, then monthly for 3 thru October 31, 2024. Results of audits will be shared at QAPI meetings. DON re-educated ADON and PRN nurses via e-mail 05/23/2024 policy and procedures on medication errors. Follow-up was provided with each nurse by DON. Results will be shared at QAPI meetings.	07/01/2024

Heather Janes, Administrator, 06/04/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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{S 680}	Continued From page 4 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 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 Treatment Orders policy revealed the following: *"If medications assistance and/or administration was not completed as prescribed, documentation must include:" -"Notification of provider". *"Medication errors will be reported to the licensed nurse, Administrator, and resident's provider, and an entry made in the resident's medical record."	{S 680}		

Heather Janes, Administrator, 06/04/2024

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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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{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 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 exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and clean storage rooms. In any unoccupied service area, ventilation may be reduced or discontinued if the	{S 990}		

Heather Janes, Administrator, 06/04/2024

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{S 990}	Continued From page 6 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) review from the 3/27/24 survey with a completion date of 5/10/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S990 to install exhaust ventilation for three of three storage rooms and one laundry room. Findings include: 1. Interview with the administrator A on 5/28/24 at 11:25 a.m. revealed the contractor had not completed the necessary wiring for the exhaust fan ventilation installations.	{S 990}	Facility has confirmed that Electrician has not provided a timeline for installation completion. Administrator and Director of Maintenance are in contact and will let DOH know when updates are available regarding timeline. Will continue to be in contact with vendor. Administrator or designee will notify DOH if contractor cannot meet the date of 7/1/24	07/01/2024
{S1039}	44:70:10:32 Electrical Distribution System 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.	{S1039}		

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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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{S1039}	Continued From page 7 This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 5/10/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S1039 to install a generator annunciator in a 24-hour manned location. Findings include: 1. Interview with the administrator A on 5/28/24 at 11:25 a.m. revealed the contractor had not completed the necessary wiring for the generator annunciator installation.	{S1039}	Facility confirmed timeline with Electrician, wiring to be connected and parts to be received and delivered. Administrator and Director of Maintenance to continue communication with Electrician.	07/01/2024

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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	**1000 YELLOWSTONE STREET FORT PIERRE, SD 57532**

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{S 000}	Compliance Statement An onsite revisit survey was conducted on 5/20/24 and 5/28/24 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 3/27/24. Peaceful Pines Senior Living - Fort Pierre was found not in compliance with the following requirements: S169, S296, S990, S680 and S1039.	{S 000}	We will have a read in read out access on the front door that all approved residents and staff can operate after hours. We will also have a door pressure sensor on the breakaway function of the door, that is tied to an alarm near the nurses' station. This alarm if tripped, would need to be reset at the door after it is reviewed by staff to ensure the event is safe for all residents and staff. Tech involved: RFID reader on either side of the door, Pressure sensor in the door, door sensor alarm at nurse's station. Equipment is on order, awaiting electrician install. Once door alarm is installed, staff will audit for 12 months (thru February 2025). Maintenance or designee will audit weekly for alarm compliance. Results will be shared at QAPI meeting. Administrator or designee will notify DOH if contractor cannot meet the date of 7/1/24	07/01/2024
{S 169}	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 5/1/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S169 to install an electrically activated audible alarm for the main entrance/exit. Findings include: 1. Interview with administrator A on 5/28/24 at 11:15 a.m. revealed an acceptable solution for the door alarming issue had not yet been determined.	{S 169}		

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

Heather Janes , Administrator, 06/04/2024

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{S 296}	Continued From page 1	{S 296}		
{S 296}	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not	{S 296}	Personnel Training (EduCare) has been completed by Employees L, Q, R, S completed by the deadline given (June 24, 2024). Transcripts are complete and available through EduCare. Results will be shared at QAPI meetings. Administrator or designee will continue to audit through February 2025.	06/24/ 2024

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{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.
-Employees Q and R regarding incident and disease reporting.
-Employee Q regarding emergency preparedness.

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

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{S 296}	Continued From page 3 training revealed: *She had sent out multiple email reminders to all employees. -Employees L, Q, R, and S had not completed all their training. *She confirmed the POC from the 3/27/24 survey was not completed.	{S 296}		
{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. This Administrative Rule of South Dakota is not 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 S680 "The DON [director of nursing] or a designee will conduct weekly audits on all resident MARs [medication administration records] to ensure that no medication errors have been made." Interview and review of medication error reports on 5/20/24 at 10:10 a.m. with DON C and assistant director of nursing (ADON) U regarding	{S 680}	Weekly audits for medication errors are conducted by DON or designee to ensure reporting and documentation of each medication error are documented correctly per policy and procedure. Reviewed weekly for 8 weeks, then monthly for 3 thru October 31, 2024. Results of audits will be shared at QAPI meetings. DON re-educated ADON and PRN nurses via e-mail 05/23/2024 policy and procedures on medication errors. Follow-up was provided with each nurse by DON. Results will be shared at QAPI meetings.	07/01/2024

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PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

(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 680}	Continued From page 4 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 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 Treatment Orders policy revealed the following: *"If medications assistance and/or administration was not completed as prescribed, documentation must include:" -"Notification of provider". *"Medication errors will be reported to the licensed nurse, Administrator, and resident's provider, and an entry made in the resident's medical record."	{S 680}		

Heather Janes, Administrator, 06/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80072	A. BUILDING: ______ B. WING ______	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIERRE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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{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 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 exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and clean storage rooms. In any unoccupied service area, ventilation may be reduced or discontinued if the	{S 990}		

Heather Janes, Administrator, 06/04/2024

South Dakota Department of Health

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	80072	A. BUILDING: ________ B. WING ________	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER: **PEACEFUL PINES SENIOR LIVING - FORT PIERRE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1000 YELLOWSTONE STREET FORT PIERRE, SD 57532**

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{S 990}	Continued From page 6 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) review from the 3/27/24 survey with a completion date of 5/10/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S990 to install exhaust ventilation for three of three storage rooms and one laundry room. Findings include: 1. Interview with the administrator A on 5/28/24 at 11:25 a.m. revealed the contractor had not completed the necessary wiring for the exhaust fan ventilation installations.	{S 990}	Facility has confirmed that Electrician has not provided a timeline for installation completion. Administrator and Director of Maintenance are in contact and will let DOH know when updates are available regarding timeline. Will continue to be in contact with vendor. Administrator or designee will notify DOH if contractor cannot meet the date of 7/1/24	07/01/2024
{S1039}	44:70:10:32 Electrical Distribution System 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.	{S1039}		

Heather Janes, Administrator, 06/04/2024

South Dakota Department of Health

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	80072	A. BUILDING: ______ B. WING ______	R-C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIERRE	**1000 YELLOWSTONE STREET FORT PIERRE, SD 57532**

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{S1039}	Continued From page 7 This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 5/10/24, the provider failed to provide documentation and/or evidence that the POC was followed for the previously cited deficiency S1039 to install a generator annunciator in a 24-hour manned location. Findings include: 1. Interview with the administrator A on 5/28/24 at 11:25 a.m. revealed the contractor had not completed the necessary wiring for the generator annunciator installation.	{S1039}	Facility confirmed timeline with Electrician, wiring to be connected and parts to be received and delivered. Administrator and Director of Maintenance to continue communication with Electrician.	07/01/2024

Heather Janes, Administrator, 06/04/2024

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80072	A. BUILDING: ______ B. WING ______	R 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - FORT PIE	1000 YELLOWSTONE STREET FORT PIERRE, SD 57532

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{S 000}	Compliance Statement 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.	{S 000}		

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