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
	46761	A. BUILDING: _____ B. WING _____	09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE RETIREMENT COMMUNITY	4504 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 9/22/26 through 9/24/26. Avera Prince of Peace Retirement Community - Oakwood was found not in compliance with the following requirements: S405, S450, and S685.	S 000		
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure the resident's service plan (personalized plan that addresses a resident's care needs, goals, and interventions) addressed the current needs for one of three sampled residents (1). Findings include: 1. Observation and interview on 9/22/26 at 3:07 p.m. with resident 1 in his room revealed he had a nebulizer (a device that converts liquid medication into an inhalable mist) machine sitting next to his recliner chair. He stated he administered his albuterol inhaler himself, while he pulled the inhaler out of his right pants pocket. He completed his nebulizer treatments three	S 405	1. **Corrective action for resident affected** A nursing assessment will be completed to determine the ability of Resident #1 to safely self-administer medications by 10/23/26. Resident #1's service plan will be reviewed and revised to accurately reflect medication administration responsibilities, including inhaler and nebulizer use after set-up, by 10/23/26 2. **Identification of other residents at risk** A 100% audit of all assisted living resident service plans will be completed to verify current medication administration responsibilities are identified, self-administration practices are reflected, and service plans accurately address current resident needs. These will be completed by November 8th, 2026. 3. **Systemic changes** A standardized Service Plan Review Process and checklist will be created and implemented by November 8th, 2026. Nursing staff and housing coordinators will be educated regarding service plan updates upon admission, significant change, medication responsibility change, and annual review at all staff in-services between 10/26/26 and 10/30/26. 4. **Monitoring** The DON, or designee, will audit 2 resident service plans weekly for eight (8) weeks. Audit results will be reviewed through the Quality Assurance process for further direction.	11/08/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Berry	Director-Nursing Home Administrator	10/20/2026

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S 405	Continued From page 1 times a day after the staff set it up for him. He turned on the nebulizer machine and shut it off when he was finished with his treatment. He stated that, "the staff come and rinse the nebulizer machine when he was finished with it." 2. Review of resident 1's electronic medical record (EMR) revealed he admitted to the facility on 8/11/25. His 8/28/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His service plan did not identify who was to administer his medications or if he was assessed to be able to self-administer his medications. 3. Interview on 9/23/26 at 3:50 p.m. with registered nurse (RN) housing coordinator C revealed she was responsible for updating the resident's service plans. She expected the service plans to address whether a resident can self-administer their medication. She updated the resident's service plans on admission, annually, whenever there was a change in their condition, and with physician's order changes. 4. Interview on 9/23/26 at 4:44 p.m. with director of nursing (DON) A and assistant director of nursing (ADON) B revealed that the resident's service plans needed to be updated when there was a significant change in their condition, and RN housing coordinator C updated them annually. He confirmed the provider did not have a service plan policy and referred to the state regulation for the resident's service plans being updated.	S 405		
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic	S 450		11/08/2026

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S 450	Continued From page 2 service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard food safety and sanitation practices regarding: One of one flattop grill, one of four convection ovens, and two of several floor drains in the main kitchen; Food items were not labeled and dated in a reach-in cooler and the alternative meal refrigerator in the main kitchen; Food items had not been discarded on or before the use-by date according to the provider's policy. Findings include: 1. Observation on 9/22/26 from 8:34 a.m. to 9:02 a.m. in the main kitchen revealed that there was a reach-in cooler with several doors located underneath the windows that faced the café area. Inside the cooler, several containers of food were not labeled or dated, including banana peppers, shredded cheese, diced tomatoes, sliced cucumbers, and diced red and green peppers. There was a container of white onion slices with a date of 9/10 written on it. There was a container of deli meat that was not labeled with what type of meat it was, and had the date 9/16 written on it. In the back of the cooler, there was half of a red onion wrapped in plastic cling wrap. That onion	S 450	**1. Corrective Action for Residents Affected** The flattop grill, one convection oven, and two floor drains in the main kitchen along with the floor drain under the dishwasher and the caulking sealant in the dish room were thoroughly cleaned. Food items in the reach-in cooler and alternative meal refrigerator were also checked for labeling, and discarded not labeled or after the use-by-date. **2. Identification of Other Residents/Areas at Risk** All areas were checked for cleanliness and thoroughly cleaned if determined to be unsanitary. All food items were also checked to ensure they were accurately labeled with a use-by-date and discarded when expired. **3. Systemic Changes** The cleaning sheet was updated to include sanitation of the noted areas. A new door was ordered on 10/13/2026 to replace the glass door of the Southbend G-Series convection over. All Dietary employees will received education on the cleaning sheet along with dating and discarding of food items the week of October 26th by the RN Supervisor or designee. **4. Monitoring** The cleaning sheet will be audited 3x per week for 12 weeks by the Support Service Manager or designee along with a visual inspection of the cleaning areas. The fridges will also be audited 3x per week for 12 weeks by the Support Services Manager or designee to ensure food items have a use-by-date and expired items have been purged timely. Results will be shared by the Support Service Manager or designee with the monthly QAPI committee for review and direction.	11/08/2026

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S 450	Continued From page 3 had a date of 7/29 written on it, and the onion had partially turned black with rot. The floor drain under the two-compartment sink, located underneath the spice shelf, was covered in a black, red, and green discolored grime. There was also a large quantity of cooked noodles in the drain. The grease trap drawer under the flattop grill had a large buildup of food and grease around the drawer and was difficult to open. The grease was dripping from the drawer, and another drip pan was placed on the floor to catch the excess grease. There was a buildup of dust between the glass panels of one of the Southbend G-Series convection ovens, that was consistent with it having a broken or malfunctioning seal. In the refrigerator labeled "alternative meal fridge," there was a container of canned peaches that was labeled "9/9/26 to 9/12/26," a container of mandarin oranges labeled "9/10/26," a container of chocolate pudding labeled "9/8," and another container of a pureed substance labeled "pumpkin bar 9/15." 2. Observation and interview on 9/24/26 at 8:55 a.m. in the dish room with dietary server Y revealed there was a significant buildup of an unidentified black substance in the floor drain under the dishwasher, on the floors and walls under the dishwasher, on the caulking sealant behind the water sprayer and garbage disposal, and in the corner of the wall to the right of the dishwasher. There was a sign posted on the dish room door	S 450		11/08/2026

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S 450	Continued From page 4 that included a list of cleaning tasks. The "PM Shift Expectations" dated 4/3/26 included, "Dish [room] floors must be sprayed down every night, including underneath counters and around the drains," "The Bleach Germicidal Cleaner needs to be poured down the drains on the floor under the 3-compartment sink and silver counters. Spray down with [the] hose after," "Use Dawn Platinum Spray to clean the stainless-steel surfaces underneath the counters," "The shelf under the dirty side of the dish room needs to be cleaned as well and no standing water left." Dietary server Y stated that the evening dietary staff were responsible for cleaning the floors and walls in the dishroom at the end of each evening shift. He said that the dietary department has a power washer that was used to spray down the dishroom floors. 3. Interview on 9/24/26 at 9:05 a.m. with cook X revealed that the evening dietary staff were responsible for deep cleaning the flattop grill and the grease trap drawer. She was aware that the flattop grill was leaking grease. She did not know how long that was happening or why it was dripping. 4. Interview on 9/24/26 at 9:21 a.m. with lead cook W revealed that he was aware that the flattop grill was leaking grease. He said that the staff cleaned it "every once and awhile." Someone came to the facility to try to fix it before, but that did not work. Regarding food storage and labeling, the facility had recently implemented a new rule that prepared food items were supposed to be labeled and could be kept for three days. After three days, the food was to be discarded.	S 450		11/08/2026

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S 450	Continued From page 5 5. Interview on 9/24/26 at 10:27 a.m. with certified dietary manager (CDM) support services manager V revealed that the food items in the reach-in cooler were supposed to be labeled and dated once prepared. Regarding the food items, such as diced tomatoes, she expected the staff to write the prepared date on the container, and the food was supposed to be discarded after three days. The three-day rule was implemented within the past couple of months. She confirmed that the staff were trained on those new expectations. The dietary staff were responsible for cleaning the floors and floor drains at the end of the day, and the maintenance department used a floor cleaning machine once per week. The staff were to mop the floors every night. She expected the staff to clean the walls in the dish room about once per month. She stated that some of the floor drains should be cleaned more often than what the staff were currently doing. She was "working on" a new cleaning checklist for the kitchen. She did not know how often the floor drains were currently cleaned. She was aware that the flattop grill was leaking grease. A contracted foodservice equipment company came to work on it twice before, but that did not fix the issue. She did not know when that contracted foodservice equipment company was last at the facility to address the issue. She explained that the leaking grease was a potential fire hazard, as there was an open flame to heat the flattop grill. She was not aware that there was a buildup of dust between the glass panels of one of the	S 450		11/08/2026

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S 450	Continued From page 6 convection ovens. She mentioned that the maintenance department staff knew how to take that machine apart to clean it. 7. Review of the provider's September 2026 Kitchen Cleaning Sheet revealed that all task items were scribbled out from September 1st to September 23rd. Items on the task list included "AM Cook - Cooks fridge, outdated food thrown, spills cleaned up," "TC Cook - Clean/Sanitize under counters," "PM Cook - Shelf [in between] counters cleaned/everything put back and sanitized," "Baker - Fridge outside dishroom (outdated food thrown)." 8. Review of the provider's September 2026 PM Closing Task Sheet revealed that the task list was assigned by the neighborhoods the staff were scheduled to work in. There were instructions on the bottom of the page that read, "This needs to be completed [every night] by [the] neighborhood that is assigned to the task. No one can leave until the tasks assigned to 'everyone' are completed and [the] PM cook confirms tasks are done. Initial once complete." The staff person assigned to the Oakwood assisted living center was supposed to mop and spray down the dishroom floor. That task was marked as completed on 9/1, 9/3, 9/5, 9/6, 9/9, 9/10, 9/12, 9/13, 9/18, and 9/20. The staff person assigned to the "1st floor" was responsible for cleaning the countertops in the dishroom. That task was marked as completed on 9/5, 9/6, 9/9 through 9/14, 9/18, and 9/20. The staff person assigned to the "TCU" was	S 450		11/08/2026

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S 450	Continued From page 7 responsible for polishing the stainless steel in the dishroom. That task was marked as completed on 9/1 through 9/6, 9/9, 9/12, 9/13, 9/18, and 9/20. Neither the Kitchen Cleaning Sheet nor the PM Closing Task Sheet included instructions for the staff to clean the convection ovens or the flattop grill. 9. Review of the provider's June 2026 Food Safety and Sanitation LTC (Long Term Care) Division Policy revealed that there were eight pages in the policy. Pages two and three were missing from the copy of the policy given to the survey team. Under the section titled "Food Preparation and Service," "Food is served as soon as possible. Leftover food is treated as recommended by Food Service Code. All leftover food is discarded after 3 days (72 [hours]). All perishable food items are labeled and dated prior to refrigeration or freezing." Under the section titled "Equipment," "Ovens and oven racks in the kitchen are cleaned thoroughly once a month, and/or after spills occur." "The floor well drain is cleaned weekly and as needed." "Stove top and grill are cleaned after each meal." "Cleaning schedules are posted & include frequency, position responsible and signed off when completed." She confirmed that the dietary staff were responsible for cleaning the floors and floor drains at the end of the day, and the maintenance department used a floor cleaning machine once per week. The staff mopped every night. She expected staff to clean the walls in the dish room about once per month.	S 450		11/08/2026

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S 450	Continued From page 8 She confirmed that some of the floor drains should be cleaned more often than what they were currently doing. She was "working on" a new cleaning checklist for the kitchen. She did not know how often the floor drains were currently cleaned. She was aware that the flattop grill was leaking grease. A contracted foodservice equipment company came to work on it twice before but that did not fix the issue. She does not know when that contracted foodservice equipment company was last at the facility to address the issue. She explained that the leaking grease was a potential fire hazard as there was an open flame to heat the flattop grill. She was not aware that there was a buildup of dust between the glass panels of one of the convection ovens. She mentioned that the maintenance department knew how to take that machine apart to clean it. She confirmed that the dietary staff were responsible for keeping the satellite kitchenettes clean including the counters, the fridge, and the freezer. The heated food carts were supposed to be wiped down after each shift, and the evening staff removed, cleaned, and replaced the trays inside the food carts at the end of each night. 6. Review of the provider's Kitchen Cleaning Sheet from September 2026 revealed that all task items had been scribbled out from September 1st to September 23rd, potentially as if no one had marked those tasks as completed or the checklist was not available until September 23rd. Items on the task list included "AM Cook - Cooks	S 450		11/08/2026

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S 450	Continued From page 9	S 450		

fridge, outdated food thrown, spills cleaned up," "TC Cook - Clean/Sanitize under counters," "PM Cook - Shelf [in between] counters cleaned/everything put back and sanitized," "Baker - Fridge outside dishroom (outdated food thrown)."

7. Review of the provider's September 2026 PM Closing Task Sheet revealed that the task list was split up by where an employee was assigned to. There were instructions on the bottom of the page that read, "This needs to be completed [every night] by [the] neighborhood that is assigned to the task. No one can leave until the tasks assigned to "everyone" are completed and [the] PM cook confirms tasks are done. Initial once complete."

The person assigned to the Oakwood assisted living center was supposed to mop and spray down the dishroom floor. That task had only been marked as having been completed on 9/1, 9/3, 9/5, 9/6, 9/9, 9/10, 9/12, 9/13, 9/18, and 9/20.

"Everyone" was assigned to clean the inside and outside of the red boxes (the heated food carts). That task had been completed on every day except for 9/1, 9/2, 9/15, 9/17, 9/19, and 9/22.

The person assigned to the "1st floor" was responsible for cleaning the counter tops in the dishroom. That task had only been marked as having been completed on 9/5, 9/6, 9/9 through 9/14, 9/18, and 9/20.

The person assigned to the "TCU" was responsible for polishing the stainless steel in the dishroom. That task had only been marked as having been completed on 9/1 through 9/6, 9/9, 9/12, 9/13, 9/18, and 9/20.

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S 450	Continued From page 10 Neither the Kitchen Cleaning Sheet nor the PM Closing Task Sheet had instructions for staff to clean the convection ovens or the flattop grill. 8. Review of the provider's June 2026 Food Safety and Sanitation LTC Division Policy revealed that there were eight pages in the policy. Pages two and three were missing from the copy of the policy given to the survey team. Under the section titled "Food Preparation and Service," "Food is served as soon as possible. Leftover food is treated as recommended by Food Service Code. All leftover food is discarded after 3 days (72 [hours]). All perishable food items are labeled and dated prior to refrigeration or freezing." Under the section titled "Equipment," "Ovens and oven racks in the kitchen are cleaned thoroughly once a month, and/or after spills occur." "The floor well drain is cleaned weekly and as needed." "Stove top and grill are cleaned after each meal." "Cleaning schedules are posted & include frequency, position responsible and signed off when completed."	S 450		
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	S 685		11/08/2026

STATE FORM
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S 685	Continued From page 11 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 observation, interview, record review, and policy review, the provider failed to ensure the resident's ability to safely self-administer medications for one of one sampled resident (1) who self-administered his nebulizer (a device that converts liquid medication into an inhalable mist) and inhaler medications without a completed medication self-assessment or a physician's order. Findings include: 1. Observation and interview on 9/22/26 at 3:07 p.m. with resident 1 in his room revealed he had a nebulizer machine sitting next to his recliner chair. He stated he administered his albuterol inhaler himself, while he pulled the inhaler out of his right pants pocket. He completed his nebulizer treatments three times a day after the staff set it up for him. He turned on the nebulizer machine and shut it off when he was finished with his treatment. He stated that, "the staff come and rinse the nebulizer machine when he was finished with it." 2. Review of resident 1's electronic medical	S 685	1. **Corrective action for resident affected** Resident #1 will be assessed for safe self-administration of medications by 10/23/26 Appropriate physician orders were obtained on 9/23/26. The Service Plan will be updated to show medication storage responsibility and required reassessments by 10/23/26. 2. **Identification of other residents at risk** A 100% audit of all assisted living residents who self-administer medications will be completed to verify physician authorization, completion of self-administration assessments, medication storage responsibility, and required reassessments by November 8th, 2026. Any required updates will be remedied quickly. 3. **Systemic changes** The self-administration policy was reviewed on 10/16/26 by the Director of Nursing, Assistant Director of Nursing, and RN Housing Coordinator. A self-administration checklist will be developed to require completion of nursing assessment, provider order, service plan update, and resident education before self-administration begins by October 23rd, 2026. A tracking system for quarterly reassessments will be created by October 23rd, 2026, and staff will be educated on requirements at all staff in-services between 10/23/26 and 10/30/26. 4. **Monitoring** The DON, or designee, will review 2 residents weekly that self-administer medications for 8 weeks to ensure they have an appropriate assessment and physician order authorizing self-administration. Results will be reviewed through the Quality Assurance process.	11/08/2026

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
	46761	A. BUILDING: _____ B. WING _____	09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 685	Continued From page 12	S 685		

record (EMR) revealed he was admitted to the facility on 8/11/25. His 8/28/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had 7/21/26 physician's order for albuterol HFA (a quick relief rescue inhaler that opens your airways to treat or prevent sudden wheezing, coughing, and trouble breathing) 90 microgram (mcg)/act (metered dose) inhaler to inhale two puffs every four hours if needed for wheezing or shortness of breath. He had a 9/15/26 physician's order for ipratropium-albuterol (Duo-Neb) 0.5-2.5 milligrams (mg)/3 milliliter (mL) nebulizer solution to take 3 mL by nebulization in the morning, and 3 mL in the evening, and 3 mL before bedtime daily. There was no medication self-administration assessment or physician's order to self-administer his medications in his EMR record.

3. Interview on 9/23/26 at 1:39 p.m. with certified nursing assistant (CNA) D revealed on 9/22/26 when she administered resident 1's Duo-Neb medication, she did not stay with the resident during the nebulizer treatment. She agreed he did not have a physician's order to self-administer his ipratropium-albuterol (Duo-Neb) nebulizer medication or his albuterol inhaler. She knew a resident was able to self-administer their medication when they had a physician's order indicating the resident could self-administer the medication.

4. Interview on 9/23/26 at 3:50 p.m. with registered nurse (RN) housing coordinator C revealed that when a resident wished to self-administer their medication, they would let her know. An assessment for self-administration of medication would be completed. A physician's order would be obtained. The licensed practical

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S 685	Continued From page 13 nurse (LPN) E, and herself would come to an agreement that the resident was safe to self-administer their medications. In the resident's EMR she would make the medication a self-administration order. She would then give the resident a monthly medication administration (MAR) sheet with the medication listed and go over how the resident was to document the medication every time they took it. She would provide a new MAR sheet monthly and scan the old MAR sheet into the resident's EMR. The resident would be assessed for medication self-administration quarterly. She agreed the assessment should be completed before the resident was given the medication to self-administer. She agreed resident 1 did not have a physician's order to self-administer his Duo-Neb or his albuterol inhaler, or a completed medication self-administration assessment in his EMR for those medications. 5. Interview on 9/23/26 at 4:44 p.m. with director of nursing (DON) A and assistant director of nursing (ADON) B revealed that a resident who wished to self-administer their medications needed to be assessed for safety and have a physician's order for the medication self-administration. 6. Review of the provider's May 2026 Self-Administration of Medications policy revealed "It is the policy of this facility that if a resident requests to self-administer medication(s), the interdisciplinary team (IDT) will assess the resident to determine if the practice of self-administration of medications is clinically appropriate, safe and feasible. The resident has the right to defer the responsibility to the facility. A resident may only self-administer medications after the IDT has determined which medications	S 685		11/08/2026

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S 685	Continued From page 14 may be safely self-administered. A. If a resident requests to self-administer medication, an assessment will be completed and reviewed by the interdisciplinary team (IDT). This will be repeated quarterly or upon change in medical condition, decision-making status and as needed."	S 685		11/08/2026