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
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 12/2/25 through 12/4/25. Park Place Assisted Living was found not in compliance with the following requirements S096, S201, S320, S352, S405, S443, S450, S465, S474, S479, S0685, S775, and S791.	S 000	Secured all laundry products and cleaning chemicals in locked cabinets and designated secured areas. Removed any chemicals found accessible to residents that are deemed unsafe to have access to. Conducted a facility-wide inspection of all storage areas, including housekeeping/janitor closets, laundry rooms, and maintenance areas. Director of Environmental Services, or designee. Ensured all hazardous chemicals were properly labeled and stored in locked or secured locations. Developed and reviewed the Hazardous Materials and Chemical Storage Policy to reinforce safe storage, labeling, and access controls. Re-educated staff on chemical safety and proper storage requirements. Director of Environmental Services or designee. Implemented a standardized checklist for weekly inspections of chemical storage areas. Ensured Safety Data Sheets (SDS) are readily available and up to date.	1/18/2026
S 096	44:70:02:05 Housekeeping Cleaning Methods And Equipment Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, South Dakota Assisted Living license review, care record review, and policy review, the provider failed to safely secure laundry cleaning products and other chemicals to avoid the potential for injury or danger to occupants in two of two laundry rooms. Findings include: 1. Observation on 12/2/25 at 8:45 a.m. of the	S 096		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Liz DeBerg | TITLE: Administrator | (X6) DATE: 1/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 096	Continued From page 1 second-floor laundry room revealed: *The door to the laundry room was open, and the light was on. *There was a cupboard on the wall with a sign that indicated "Cupboard MUST remain locked at all times." Both doors of that cupboard were open. *That cupboard contained: -Two wall-mounted laundry detergent and laundry sanitizer dispensers. -A bottle of Lysol toilet cleaner. -A bottle of saline eye wash. -A package of "Stay Dry Wash Cloths." *On the counter next to the cabinet was: -A spray bottle of "Q.T. 5" disinfectant. -A bottle of "Take Down Fresh & Clean" cleaner and deodorizer. -A spray bottle of "Clorox Healthcare Fuzion" cleaner and disinfectant. -A bottle of "Clax Magic Multi" spot remover. -A clear spray bottle marked "39 Glass + Floo peroxide cleaner." The writing was smudged and difficult to read. *There was no staff visible on the second floor at that time. 2. Observation on 12/2/25 at 8:53 a.m. of the first-floor laundry room revealed: *The door to the laundry room was open, and the light was on. *There was a cupboard on the wall with a sign that indicated "Cupboard MUST remain locked at all times." Both doors of that cupboard were open. *That cupboard contained: -Three wall-mounted laundry detergent and laundry sanitizer dispensers. -A bottle of "Clax Magic Multi" spot remover. -One bottle with a flip top and one spray bottle of surfactant stain remover.	S 096	The Administrator or designee will conduct weekly inspections of chemical storage areas for 4 weeks, then monthly thereafter. Findings will be documented and reviewed as part of QAPI. Any identified issues will be corrected immediately with staff re-education or disciplinary action as appropriate.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 096	Continued From page 2 3. Interview on 12/2/25 at 10:45 a.m. with unlicensed assistive personnel (UAP) G revealed: *The signs indicating that the cabinet doors needed to remain locked were old. *In March of 2025, the resident council had determined that residents could do their own laundry. The doors to the laundry rooms and the cabinets that contained the laundry cleaning products and other chemicals had remained open and unlocked since that time. *Some residents did their laundry independently, some residents required assistance with doing their laundry, and others wanted staff to complete all of their laundry for them. *There were residents with cognitive impairment who lived on the first and second floors. 4. Interview on 12/2/25 at 11:00 a.m. with administrator A revealed: *The decision had been made in March or April of 2025 to allow the laundry rooms and laundry cleaning products to be accessible to all residents, so that residents who wanted to complete their laundry would not have been restricted. *She had reviewed the resident council minutes from that time period and was unable to find documentation of the discussion about resident access to the laundry rooms and chemicals stored in that area. *She felt that the risks involved with leaving the laundry room doors open, the laundry cleaning products, and other chemicals accessible to all residents had been assessed and reviewed at that time. *She was unable to provide documentation of that safety assessment. *She felt that no current residents were at risk from the laundry cleaning products and other	S 096		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 096	Continued From page 3 chemicals being available in the laundry room. 5. Review of the provider's 7/1/25 assisted living license revealed they had the optional service license for the care of cognitively impaired residents. 6. Review of the resident list requested at the entrance conference on 12/2/25 revealed: *The current census was 29. *There were 10 residents with a Brief Interview for Mental Status (BIMS) assessment score of 10 or below, which indicated they were moderately or severely cognitively impaired. *There were 11 residents marked "-", which indicated that a BIMS assessment score, or other cognitive assessment score, was not found in the resident's care record. 7. Review of the provider's revised 2/5/25 Laundry and Bedding policy revealed it did not address the storage of laundry cleaning products or other chemicals. 8. Review of the provider's revised April 2013 Hazardous Chemicals Inventory Listing policy revealed it did not address the storage of laundry cleaning products or other chemicals.	S 096		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not	S 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 201	Continued From page 4 operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to maintain two of two fire rated rolling steel doors on the second floor were in operating condition. Findings include: 1. Observation and interview on 12/2/25 at 1:45 p.m. with the head of maintenance in regards to the two fire rated rolling steel doors on the second floor revealed: *The hold open device for the fire rated doors was equipped with a test feature. *The doors were not on a routine maintenance plan and had not been tested by the provider. Interview with the head of maintenance on 12/2/25 at 2:15 p.m. revealed: *He was not present when the test company had tested the doors actuators. *When the test company tested the doors they did not allow the door latching mechanism to release. *He did not know if the hold open device was tested to ensure it would release with the smoke detector on either side of the fire door. B. Based on observation and interview, the provider failed to maintain one of one elevators was in operating condition. Findings include: 1. Observation and interview on 12/2/25 at 1:55	S 201	Reviewed the fire drill and emergency preparedness records to identify missing or incomplete drills. Conducted required fire drills to ensure staff were familiar with evacuation procedures and resident safety protocols. Director of Environmental Services or designee. Reviewed emergency procedures with staff to ensure residents would be assisted appropriately during an emergency. Ensured all residents were included in the emergency preparedness planning. Verified staff knowledge of resident-specific needs, evacuation routes, and emergency roles. Confirmed emergency equipment and exits were accessible and functional.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 201	Continued From page 5 p.m. with the head of maintenance in regards to the elevator revealed: *The elevator was tested for operation during the fire drill. It ran up and down to the second floor without hesitation. Interview with the head of maintenance on 12/2/25 at 2:20 p.m. revealed: *There was no documentation showing the elevator recall system was in working condition. *He stated the elevator representative indicated smoke detection on the first and second floor controlled the two-stage recall operation.	S 201	Reviewed and revised the Fire Safety and Emergency Preparedness Policy to reinforce drill frequency, staff responsibilities, evacuation procedures, testing of fire curtain/rolling doors, elevator recall testing and documentation requirements. Director of Environmental Services or designee. Re-educated all staff on the fire emergency evacuation protocols. Implemented a standardized fire drill and emergency drill schedule with documentation tools. The roll down curtains and elevator recall will be tested monthly by the Director of Environmental Servies or designee with the results documented. Ensured drills are conducted on all shifts and varied scenarios are practiced. The Administrator or designee will review fire drill and emergency drill documentation monthly. Compliance will be monitored through QAPI. Any missed drills or identified issues will be corrected promptly with staff re-education and follow-up drills.	1/18/2026
S 320	44:70:08 Prevention And Control Of Pneumonia Each facility shall arrange for an immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage a resident to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure one of six (5) sampled residents had received the pneumococcal vaccine, declined, or received the vaccination at a different location within 14 days of admission. Findings include: 1. Review of resident 5's care record revealed: *Resident 5's admission date was 6/17/24. *There was no documentation that indicated that	S 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 320	Continued From page 6 resident 5 had declined or received the pneumococcal vaccine at a different location within the 14 days following her admission. 2. Interview with registered nurse (RN)/director of nursing (DON) B on 12/4/25 at 4:30 p.m. and again at 5:30 p.m. revealed: *The nurse that had been responsible for ensuring the task had been completed left her position abruptly in early 2025 and the full-time nurse position had not been filled until several months prior to the survey. *Her primary location was as the DON of the long-term care facility across the street. *They were unable to locate the documentation that resident 5 had received or declined the vaccine. 3. A policy for pneumococcal vaccination was requested from RN/DON B on 12/4/25 at 1:40 p.m. and was not received prior to the exit from the survey.	S 320	Reviewed the identified residents' medical records for pneumococcal vaccination status, physician orders, and consent or refusal documentation. Director of Nursing or designee. Obtained physician orders as needed and offered the pneumococcal vaccine to eligible residents. Administered the vaccine per protocol or documented resident/legal representative refusal. Updated the medical record to accurately reflect vaccination status. Conducted a facility-wide audit of all resident records to verify pneumococcal vaccination status. Director of Nursing or designee.	1/18/2026
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure that an evaluation of needs was completed: *Thirty days after admission, for five of six	S 352	Identified residents who were eligible and ensured vaccination was offered, administered, or refusal appropriately documented. Verified availability of the vaccine and standing orders. Developed and reviewed the Immunization Policy to reinforce pneumococcal vaccination assessment, consent, administration, and documentation requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 352	Continued From page 7 sampled residents (2, 3, 4, 5, and 6). *Annually for three of six sampled residents (1, 5, and 6). Findings include: 1. Review of resident 1's care record revealed: *She was admitted on 8/4/20. *An annual evaluation of care needs was completed on 10/9/24. There was no documentation that an annual evaluation of needs had been completed since 10/9/24. 2. Review of resident 2's care record revealed: *He was admitted on 1/7/25. *There was no documentation that his 30-day evaluation of needs had been completed. 3. Review of resident 3's care record revealed: *She was admitted on 12/4/24. *There was no documentation that her 30-day evaluation of needs had been completed. 4. Review of resident 4's care record revealed: *He had been admitted on 8/29/25. *There was no documentation that his 30-day evaluation of needs had been completed. 5. Review of resident 5's care record revealed: *She had been admitted on 6/17/24. *There was no documentation that her 30-day or annual evaluation of resident needs had been completed. 6. Review of resident 6's care record revealed: *She had been admitted on 9/12/24. *There was no documentation that her 30-day or annual evaluation of resident needs had been completed.	S 352	Re-educated nursing staff on pneumococcal vaccine indications, schedules, and documentation standards. Director of Nursing or designee. Implemented a standardized immunization tracking tool to monitor pneumococcal vaccination status for all residents. Ensured standing physician orders are maintained for pneumococcal vaccination. The Infection Preventionist or Director of Nursing will review pneumococcal vaccination tracking logs monthly. Compliance data will be reported to the QAPI Committee. Any identified gaps will be addressed promptly with corrective action and staff re-education.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 352	Continued From page 8 7. Interview on 12/3/25 at 11:26 a.m. with registered nurse (RN)/director of nursing (DON) B revealed: *She was unable to locate documentation in the electronic or paper care records that a 30-day evaluation of needs had been completed for residents 2 or 3. *She was unable to locate documentation in the electronic or paper care records that an annual evaluation of resident care needs had been completed for resident 1. *The previous case manager completed resident care needs assessments and was no longer employed since March 2025. *A new case manager was hired in September 2025, and they were trying to catch up on documentation that had not been completed during that time. *She was unaware that a 30-day evaluation of needs was required for residents who lived in assisted living facilities and thought that resident needs assessments were completed on admission, quarterly, and with significant changes in condition. 8. On 12/3/25 at 4:50 p.m., administrator A was requested to provide an assessment schedule policy. The provider provided a 2024 National Center for Assisted Living document that revealed: *"An assisted living center must ensure an evaluation of each resident's care needs at the time of admission, 30 days after admission and annually thereafter to determine if the facility can meet the needs for each resident." 9. Interview on 12/4/25 at 4:15 p.m. with administrator A revealed: *She confirmed that the above-listed documentation for residents 1, 2, 3, 4, 5, and 6	S 352	Reviewed the identified residents' admission records for completeness, including assessments, consents, physician orders, and care plans. Completed any missing or incomplete admission documentation. Director of Nursing, Administrator, or designee. Communicated resident needs, diagnoses, and care requirements to all relevant departments. Conducted a facility-wide audit of all admissions to ensure all required admission elements were completed. Director of Nursing, Administrator, or designee. Corrected identified deficiencies and ensured interdisciplinary admission requirements were met. Developed and reviewed the Admission Policy to clarify required documentation, timelines, and staff responsibilities.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 352	Continued From page 9 was unable to be located in their electronic or paper care records. *It was the provider's regular process that the case manager would complete the resident care needs evaluations. *The provider had a change in case management in March or April 2025, and she was aware that some documentation had not been completed timely. *She was unaware that an evaluation of resident needs was required to have been completed 30 days after admission. 10. Interview on 12/4/25 at 4:30 p.m. with RN/DON B and RN/case manager C revealed there had not been an evaluation of resident needs done at 30 days for all residents since they were unaware of the requirement.	S 352	Re-educated admissions, nursing, and interdisciplinary staff on the standardized admission process. Director of Nursing or designee. Implemented an admission checklist to ensure completion of all required assessments, consents, and notifications. The Director of Nursing or designee will review admission records weekly for 4 weeks, then monthly thereafter. Findings will be reported to the QAPI Committee. Identified issues will be addressed with corrective action and staff re-education as needed.	1/18/2026
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, care record review, and policy review, the provider failed to ensure the written service plan addressed the current care needs for four of six sampled residents (1, 2, 5, and 6). Findings include:	S 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 405	Continued From page 10 1. Observation and interview on 12/2/25 at 3:25 p.m. with resident 2 in his room revealed: *He was alone in his room and turned off his nebulizer machine (a device that converts liquid medication into an inhalable mist) as the surveyor entered his room. *There was an electric scooter parked outside his door. He stated he used that scooter when he left his room to go to the dining room or out of the facility when the weather was nice. *He stated that staff members administer most of his medications, but he administered his nebulizer treatments independently and kept his inhaler (a portable device for administering inhaled medication) and nitroglycerine (a fast-acting medication used to relieve or prevent episodes of chest pain) in his room. Review of resident 2's care record revealed: *He was admitted on 1/7/25. *His 1/14/25 (Provider's name) Standing Orders indicated his physician had marked "Self-Administer medications after set-up." There was no indication which medications resident 2 was to self-administer. *His service plan did not include his use of his electric scooter, or that he self-administered nebulizer treatments, inhaler, or nitroglycerine. *There was no documentation that his service plan had been reviewed since 3/16/25. *"(Specify)" appeared four times in his service plan, where resident-specific information had not been entered. 2. Interview on 12/2/25 at 3:45 p.m. with resident 1 in her room revealed: *She was on a gluten-free diet. *She stated that she was not allowed to keep her medications in her room, but was unsure if	S 405	Reviewed the identified residents' assessments and care plans for accuracy and completeness. Director of Nursing, Administrator or designee. Updated care plans to reflect current diagnoses, diet, needs, risks, preferences, and physician orders. Director of Nursing, Administrator, or designee. Implemented appropriate interventions and communicated updates to direct care staff. Conducted a facility-wide audit of resident care plans to ensure alignment with assessments and current conditions. Director of Nursing, Administrator, or designee. Corrected identified gaps and ensured care plans were individualized and implemented. Verified staff awareness of care plan interventions. Developed and reviewed the Care Planning Policy to reinforce timely development, interdisciplinary involvement, and ongoing updates. Re-educated nursing and interdisciplinary staff on care plan requirements, person-centered planning, and documentation standards. Director of Nursing or designee.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 405	Continued From page 11 prescription creams, eye drops, or mouthwash counted as medications because she kept those items in her room. Review of resident 1's care record revealed: *She was admitted on 8/4/20. *Her diagnoses included celiac disease, a disease in which the small intestine is hypersensitive to gluten, leading to difficulty in digesting food. *A 5/17/24 physician's order "Gluten Free Diet related to CELIAC DISEASE." *A 4/13/21 physician's order "Chlorhexidine Gluconate Solution [mouthwash]." *Her service plan with a "next review date of 6/4/25" did not include that she was on a gluten-free diet or self-administered prescription mouthwash. *"(Specify)" appeared six times in her service plan where resident-specific information had not been entered. *There was no documentation that her service plan had been reviewed since 3/27/25. 3. Review of resident 5's care record revealed: *She was admitted on 6/17/24. *A recent progress note had indicated that she currently had a chronic wound to the left elbow that required a dressing change. *A copy of her service plan was requested on 12/4/25 at 1:40 p.m. from registered nurse (RN)/director of nursing (DON) B. -RN/DON B stated on 12/4/25 at 5:30 p.m. that the requested documentation was not located. *There was no documentation to support a service plan had been established that identified resident 5's current care needs, including wound care. 4. Review of resident 6's care record revealed:	S 405	Implemented a standardized care plan review schedule and audit tool. Strengthened interdisciplinary communication to ensure care plans are updated with changes in condition. The Director of Nursing or designee will conduct weekly care plan audits for 4 weeks, then monthly thereafter. Audit results will be reviewed by the QAPI Committee. Identified deficiencies will be addressed with corrective action and staff re-education as needed.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 405	Continued From page 12 *She was admitted on 9/12/24. *A copy of her service plan was requested on 12/4/25 at 1:40 p.m. from RN/DON B. -RN/DON B stated on 12/4/25 at 5:30 p.m. that the requested documentation was not located. *There was no documentation to support a service plan had been established that identified resident 6's care needs. 5. Interview on 12/4/25 at 12:30 p.m. with RN/DON B revealed: *The provider used the terms service plan and care plan interchangeably. *She expected the case manager to complete a service plan when a resident was admitted and to update that service plan quarterly, and with any changes to the resident's care to reflect the resident's current needs. 6. Interview on 12/4/25 at 4:15 p.m. with administrator A revealed: *The assisted living center used the same care plan or service plan policies as the long-term care facility across the street. *She expected that resident service plans would be completed within seven days of the resident's admission to the facility and contain specific, detailed information needed to care for that resident. She expected service plans to be updated quarterly, and with any changes in the residents' care to reflect the residents' current care needs. *It was the provider's regular process that the case manager would complete the resident service plan and update the service plan when needed. *The provider had a change in case management in March or April 2025, and she was aware that some documentation had not been completed timely.	S 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 405	Continued From page 13 7. Review of the provider's revised 2/26/25 Comprehensive Care Plans policy revealed: *"A comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment and prepared by the interdisciplinary team, composed of individuals who have knowledge of the resident and their needs ..." *"The care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments." *"The care plan will also be updated as needed by the interdisciplinary team and dated/initialed with each change."	S 405	Reviewed or completed the identified residents' cognitive assessments, care plans, and behavior monitoring. Director of Nursing or designee. Reviewed and updated the Admissions policy to include when to conduct cognition screenings and at what interval. Director of Nursing or designee. Updated care plans to reflect current cognitive status, triggers, communication needs, and safety interventions. Director of Nursing, Administrator, or designee.	1/18/2026
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure a cognitive screening was completed: *On admission for five of six sampled residents (2, 3, 4, 5, and 6). *Annually for three of six sampled residents (1, 3, and 5). Findings included: 1. Review of resident 1's care record revealed: *She was admitted on 8/4/20.	S 443	Implemented appropriate supervision, redirection techniques, and environmental supports. Communicated updated interventions to all direct care staff. Conducted a facility-wide review to identify residents with cognitive impairment or dementia. Director of Nursing or designee. Verified individualized care plans included appropriate interventions for safety, communication, routines, and behaviors. Corrected identified gaps and ensured staff awareness of resident-specific needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 443	Continued From page 14 *Her 10/6/22 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *A 4/14/25 BIMS assessment indicated "TBD [to be determined]." *There was no documentation that a cognitive assessment had been completed since 10/6/22. 2. Review of resident 2's care record revealed: *He was admitted on 1/7/25. *A 4/14/25 BIMS assessment score indicated "TBD [to be determined]." *There was no documentation that a cognitive assessment had been completed since he was admitted to the facility. 3. Review of resident 3's care record revealed: *She was admitted on 12/4/24. *Her 3/6/25 BIMS assessment indicated "In Progress." *There was no documentation that a cognitive assessment had been completed since she was admitted to the facility. 4. Review of resident 4's care record revealed: *He was admitted on 8/29/25. *There was no documentation provided to support that a BIMS assessment was completed upon admission. 5. Review of resident 5's care record revealed: *She was admitted on 6/17/24. *There was no documentation provided to support that a BIMS assessment was completed upon admission or annually. 6. Review of resident 6's care record revealed: *She was admitted on 9/12/24. *A BIMS assessment had been completed on 10/30/25 was 15, which indicated that her	S 443	Developed and reviewed the Cognitive Impairment/Dementia Care Policy to reinforce person-centered approaches and non-pharmacological interventions. Education provided to the RN Case Manager by the Director of Nursing or designee regarding the regulatory requirement for the completion of cognitive screenings at admission, yearly, and after a significant change in condition. The Director of Nursing or designee will conduct weekly audits of care plans and observations for residents with cognitive impairment for 4 weeks, then monthly thereafter. Findings will be reviewed by the QAPI Committee.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 443	Continued From page 15 cognition was intact. *There was no documentation provided to support that a BIMS assessment was completed upon admission. 7. On 12/3/25 at 4:50 p.m., administrator A was requested to provide an assessment schedule policy. The provider provided a 2024 National Center for Assisted Living document that revealed it had not addressed the requirements for frequency of cognitive assessments. 8. Interview on 12/3/25 at 11:26 a.m. with registered nurse (RN)/case manager (CM) C and RN/director of nursing (DON) B regarding resident cognitive assessments revealed: *RN/CM C confirmed that there was no documentation that a cognitive assessment had been completed for residents 2 or 3 since they were admitted to the facility. *RN/CM C confirmed that the last documented cognitive assessment for resident 1 was completed on 10/6/22, over 13 months ago. *The previous case manager completed cognitive assessments and was no longer employed since March 2025. *A new case manager was hired in September 2025, and they were trying to catch up on assessments that had not been completed during that time. *RN/DON B expected that a BIMS assessment would be completed on each resident as part of their admission assessment, annually, and with any significant change in the resident's status. 9. Interview on 12/4/25 at 4:15 p.m. with administrator A revealed: *It was the provider's regular process that the case manager would complete the residents' cognitive assessments.	S 443		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 443	Continued From page 16 *The provider had a change in case management in March or April 2025, and she was aware that some assessments had not been completed timely. *She expected that a BIMS assessment would be completed on each resident as part of their admission assessment, annually, and with any significant change in the resident's status. 10. A policy for cognitive screenings was requested from RN/DON B on 12/4/25 at 1:40 p.m. and was not received prior to the exit from the survey.	S 443	Immediately addressed identified food safety and sanitation concerns, including discarding improperly stored or expired food items. Ensured food served to residents was obtained from approved sources and prepared and served in a sanitary manner. Cleaned and sanitized affected food preparation and storage areas. Conducted an inspection of food procurement records, storage areas, refrigerators/freezers, and dry storage. Dietary Manager or designee. Verified food was obtained from approved vendors and properly labeled, dated, and stored. Corrected any identified sanitation or storage deficiencies. Reviewed and revised the Food Procurement and Sanitation Policy to reinforce approved sourcing, proper storage, rotation, and sanitation practices.	1/18/2026
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure safe and sanitary dietetic service practices were followed to prevent foodborne illness risks in one of one kitchen to: *Maintain a sanitary environment in one of one walk-in refrigerator that stored residents' food. *Ensure that food packages were dated and labeled when opened and outdated food items were discarded. *Maintain a cleanable surface for one of one dishwasher with exposed rust. *Ensure proper hand hygiene and glove use by one of one cook (E) during meal service	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 450	Continued From page 17 preparation and serving. Findings include: 1. Observation on 12/2/25 at 9:34 a.m. in the kitchen revealed: *The walk-in refrigerator contained a sign that indicated "Label & [and] Date Everything. 3 [three] day maximum storage limit." Inside that walk-in refrigerator were metal storage shelves. There was a widespread white and black substance, which appeared to be mold. That substance covered the floor under those shelves, the bottom shelf, and the legs of the metal shelves. The shelves contained resident food items on plastic trays and in plastic bins, which included: -A container covered in plastic wrap labeled "Oreo cake" dated 11/24/25. -An unlabeled and undated plastic bag with what appeared to be a cucumber. -An unlabeled and undated plastic-wrapped package of sliced cheese. -Nine opened undated juice containers. -One whole Jennie-O chicken, wrapped in plastic wrap, was directly on the bottom rack of that shelf. *The area where the clean dish rack exited the dishwasher had an uncleanable area of rust that was about five inches wide that extended approximately 18 inches under the counter. -That area was dripping water and rust onto the surfaces below. 2. Observation and interview on 12/2/25 at 10:00 a.m. with dietary manager (DM) D revealed she: *Was aware of the leak from the dishwasher that had caused the area of rust. She had reported the area to maintenance verbally "a while ago," and was hoping to get a new dishwasher. -Was unable to provide documentation that she	S 450	Re-educated dietary staff on food safety standards, including temperature control, cleaning and sanitizing, hand hygiene, glove use, and prevention of cross-contamination. Dietary Manager or designee. Implemented standardized logs for food temperatures, cleaning schedules, and vendor verification. Ensured adequate supplies of approved sanitizers and monitoring tools. The Dietary Manager or designee will conduct daily sanitation and temperature checks and weekly supervisory audits for 4 weeks, then monthly thereafter. Audit results will be reviewed by the QAPI Committee.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 450	Continued From page 18 had reported the area of rust on the dishwasher. *Was unaware of the black and white substance on the walk-in refrigerator floor and shelves. She identified the substance to be mold. *Reported concerns about the mold in the walk-in refrigerator to the maintenance department as it reoccurred. *Expected that the dietary staff would clean the walk-in refrigerator and shelves weekly. *Expected all food items to be labeled when they were opened with the date. -She confirmed that there were nine open and undated containers of juice. -She felt that the juice was safe to drink because they went through juice very quickly, but agreed that she did not know when they had been opened. *Expected all leftover food items to be labeled with the name of the item and the date they were opened. Leftover food items needed to be discarded after three days. She confirmed the above-listed items were not labeled or dated. *Expected the dietary staff members to complete the assigned weekly cleaning and document that cleaning on the cleaning schedule. 3. Interview on 12/2/25 at 10:38 a.m. with maintenance technician (MT) H revealed that the maintenance department used an electronic system to track maintenance issues, and there had not been work orders submitted regarding the rust on the dishwasher or the mold in the walk-in refrigerator. 4. Observation on 12/2/25 at 11:25 a.m. with cook (E) and DM D in the kitchen of the lunch meal preparation and serving area revealed: *Without washing her hands, cook E, put on a pair of gloves, and with those gloved hands she: -Touched the handle of the serving utensils on the	S 450	Any identified issues will be corrected immediately with staff re-education and follow-up	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 450	Continued From page 19 steam table. -Exited the kitchen to speak with resident 1. Placed her right hand on the counter and her left hand on her hip. Then handed resident 1 a can of V8 tomato juice. -Returned to the kitchen, took a plate from the rack, and with those same gloved hands removed four hot dog buns from the package and placed them on the plate, then opened the microwave and placed the plate in the microwave. -With those gloved hands, she removed the hotdog buns from the microwave and, with tongs, placed a hot dog into each bun and placed those hot dogs onto four plates. -Used a scoop and placed a scoop of potato salad onto those four plates. -Placed the four plates onto a cart and pushed that cart into the dining room. -Returned to the kitchen, removed four more hot dog buns from the package, opened the microwave, and placed them inside. *DM D instructed cook E to change her gloves. *Cook E removed those gloves and placed them on the counter between the box of gloves and the hot dog buns, and without washing her hands, put on a new pair of gloves and repeated that process until all residents had been served. *DM D instructed cook E to change her gloves with each cycle of defrosting four hot dog buns, plating four plates of resident food, and bringing that food into the dining room. 5. Interview on 12/2/25 at 4:08 p.m. with cook E revealed: *She was aware of the mold in the walk-in refrigerator and the rust by the dishwasher, but she had not told anyone. She thought that DM D knew about those problems. *Dietary staff were responsible for cleaning the kitchen, and there was a daily cleaning list that	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 450	Continued From page 20 indicated what areas were cleaned each day. *She had not cleaned the floor or the metal racks in the walk-in refrigerator because she was allergic to mold. *She confirmed that she had not washed her hands before putting on her gloves and that she had touched several surfaces in the kitchen before touching the residents' ready-to-eat hot dog buns. *She had received education on hand washing and glove use in the kitchen, but was confused about when to wear gloves and when not to because she had been told she could wear gloves when she prepared and served resident food and then was told not to. 6. Interview on 12/4/25 at 1:43 p.m. with registered dietitian (RD) I revealed: *She conducted annual in-services for the dietary staff members that included hand washing and glove use in the kitchen. *She expected that dietary staff members would wash their hands with soap and water before putting on gloves and after removing gloves. *Gloves were only to be used for touching ready-to-eat food such as hot dog buns. She instructed dietary staff members to use tongs or utensils whenever possible, but had not been aware of the mold in the walk-in refrigerator *She was not aware of the mold in the walk-in refrigerator or the rust on the dishwasher until DM D told her on 12/3/25. *She did not conduct audits of the kitchen and thought that DM D would have audited the kitchen. 7. Review of the providers' Cook Weekly Deep Cleaning Schedules for September through December 2025 revealed:	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 450	Continued From page 21 *There was one or two areas for cleaning assigned to the cook each day of the week. -In September, the cleaning was completed on 9/13/25, 9/14/25, and 9/28/25. -In October, the cleaning was completed on 10/2/25, 10/5/25, 10/12/25, 10/26/25, and 10/31/25. -In November, the cleaning was completed on 11/13/25, 11/20/25, 11/22/25, and 11/28/25. -No cleaning was marked completed in December. *"Clean walk in Cooler and Walk in Freezer floors" was scheduled to be completed each Monday and was marked completed one time on 10/2/25. *There was no cleaning of the dishwasher listed on the Cooks Weekly Deep Cleaning Schedule. 8. Review of the provider's revised 3/18/24 Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy revealed: *"Employees must wash their hands: ...whenever entering or re-entering the kitchen ...working with ready-to-eat foods; after handling soiled equipment or utensils; during food preparation as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or after reengaging in other activities that contaminate the hands." *"Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness." *"Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing."	S 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 465	Continued From page 22	S 465	A Food Supply and Emergency Preparedness policy was developed and Reviewed. To ensure the Park Place Assisted Living maintains an adequate, safe, and continuous food and water supply to meet the nutritional needs of all residents during normal operations and emergencies, in compliance with federal and state regulations. Park Place Assisted Living will maintain sufficient food, water, and related supplies to provide nutritionally adequate meals, therapeutic diets, and hydration for all residents at all times, including during emergencies, disasters, or service interruptions. This policy applies to dietary services, nursing, administration, maintenance, and any staff involved in food service or emergency preparedness. Emergency Food Supply: Shelf-stable food and potable water maintained for use during disasters or interruptions in normal food service. Therapeutic Diet: A diet ordered by a physician or qualified practitioner to meet specific medical needs.	1/18/2026
S 465	44:70:06:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned emergency menus for three days. Findings include: 1. Observation and interview on 12/4/25 at 9:50 a.m. of the provider's emergency food supply and emergency menu with dietary manager (DM) D revealed: *She did not have an on-site three-day emergency menu for the assisted living facility. *She had an emergency menu for the long-term care facility across the street, but was unsure if that menu included the assisted living residents. *She had been working on updating the three-day emergency menu to match the foods that they served to prevent keeping a separate stock of food that would expire. She felt that there was enough food on-site to feed the 29 assisted living residents, but agreed that the cooks would not know which food to	S 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 465	Continued From page 23 prepare if there was an emergency. *There was no system in place to monitor the three-day emergency food supply, and she did not know if there was enough of each required food group. 2. Interview on 12/4/25 at 1:43 p.m. with registered dietitian (RD) I revealed she: *Had approved a three-day emergency menu for the assisted living facility and expected that menu to be on-site. *Expected the provider to maintain a food supply to match the three-day emergency menu. 3. On 12/4/25 at 12:30 p.m., registered nurse (RN)/director of nursing (DON) B was requested to provide an emergency food supply menu policy. She provided a 2024 National Center for Assisted Living document that revealed: *"The facility shall maintain an on-site supply of perishable and nonperishable food to meet the requirements of planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan."	S 465	The facility will maintain a minimum of three (3) days of non-perishable food and potable water for residents and staff, or more as required by state regulation. Food supplies will accommodate all resident diets, including regular, mechanically altered, pureed, and therapeutic diets. Emergency food supplies will be stored safely, labeled clearly, and protected from contamination. All food supplies will be monitored to ensure freshness, proper rotation, and compliance with food safety standards. The facility will ensure access to alternative food preparation methods in the event of power, gas, or water disruption.	1/18/2026
S 474	44:70:06:08 Written Dietetic Policies The facility shall have written policies and procedures that govern all dietetic activities. The policies and procedures must include food handling procedures, length of duration for leftovers, and opened packages of commercially prepared food in accordance with chapter 44:02:07. The facility shall review the policies and procedures yearly and revise as necessary. This Administrative Rule of South Dakota is not	S 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 474	Continued From page 24 met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure dietetic policies were reviewed yearly and revised as necessary in one of one kitchen. Findings include: 1. Observation, interview, and review of the on-site dietary policies on 12/4/25 at 9:50 a.m. of the provider's dietetic policies with dietary manager (DM) D revealed: *The dietetic policies were last reviewed in April 2024. *She was in the process of updating the policies to reflect changes in the food code, and those updated policies were in her office across the street at the long-term care facility. *She confirmed that dietary staff members who worked in the assisted living kitchen did not work at the long-term care facility and would not have had access to those policies. 2. Interview on 12/4/25 at 1:43 p.m. with registered dietitian (RD) I revealed she: *Expected that dietetic policies would have been reviewed and revised as necessary by the facility to reflect the current food code. *Would provide consultation to DM D if there were questions about those policies. *Expected that updated dietetic policies would have been available on-site for all dietary staff members to review.	S 474	Inventory Management Dietary services will maintain an updated inventory of food and water supplies. Emergency food supplies will be reviewed at least monthly. Expiration dates will be monitored and food rotated using the First-In, First-Out (FIFO) method. Inventory records will be maintained and available for review. Storage Requirements Dry goods will be stored off the floor, in clean, dry, and temperature-controlled areas. Refrigerated and frozen foods will be maintained at required temperatures per food safety guidelines. Emergency food supplies will be stored separately or clearly identified.	1/18/2026
S 479	44:70:06:09 Written Menus The dietician shall review any menu changes from month to month. Each menu as served must meet the nutritional needs of the resident in	S 479		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 479	Continued From page 25 accordance with the orders of a physician, physician assistant, nurse practitioner, or dietician, and Dietary Guidelines for Americans, 2020-2025, United States Department of Agriculture. The facility shall file and retain a record of each menu as served for thirty days. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, provider menu review, interview, and policy review, the provider failed to ensure that dietary substitutions were reviewed and approved by the registered dietitian monthly in one of one kitchen. Findings include: 1. Observation on 12/2/25 at 11:25 a.m. with cook (E) in the kitchen of the lunch meal preparation and serving revealed: *She prepared hot dogs and potato salad for the residents' lunch that day. *When she ran out of potato salad, she substituted coleslaw. 2. Review of the provider's 12/2/25 menu revealed that pulled pork sandwiches, potato salad, V8, and a pistachio dessert were scheduled to be served. 3. Interview on 12/2/25 at 4:08 p.m. with cook E revealed she: *Prepared hot dogs because they did not have pulled pork in stock. *Substituted coleslaw for potato salad because there was not enough potato salad for all 29 residents. *Was frustrated because she frequently ran out of	S 479	Emergency Operations In the event of an emergency, the Dietary Manager or designee will assess available food and water supplies. Modified menus may be implemented while ensuring nutritional adequacy. Coordination will occur with administration and local emergency management as needed. Documentation of food usage and remaining supply will be maintained during emergencies. Education and Training Dietary and nursing staff will receive training on emergency food procedures upon hire and annually by the Dietary Manager or designee. Emergency food supply procedures will be reviewed during disaster drills. Monitoring and Quality Assurance Food supply and inventory practices will be reviewed through routine audits. Dietary Manager or designee. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. Failure to follow this policy may result in corrective action in accordance with facility policy.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 479	Continued From page 26 or did not have the food items listed on the planned menu. *Would have substituted items she knew that the residents liked. *Had not documented those substitutions and was unaware that the dietitian should have reviewed and approved those substitutions. 4. Interview and review of the provider's substitution log on 12/4/25 at 9:50 a.m. with dietary manager (DM) D revealed: *DM D had recorded the substitutions cook E had made on 12/2/25. *There were no other substitutions documented for the last six months. *She was unaware that cook E had made substitutions and had not documented them until 12/2/25. 5. Interview on 12/4/25 at 1:43 p.m. with registered dietitian (RD) I revealed she: *Expected the cooks to document when substitutions were made on the form in the menu book for her review monthly. *Was unaware that substitutions were made and not documented. 6. Review of the provider's 3/18/24 Menus policy revealed "Menu substitutions are kept on file in the substitution log in the main kitchen." Review of the provider's 3/18/24 Substitutions policy revealed: *"The food services manager, in conjunction with the clinical dietitian, may make food substitutions as appropriate or necessary. The food services shift supervisor on duty will make substitutions only when unavoidable." *"All substitutions are noted on the menu and filed in accordance with established dietary policies. Notations of substitutions must include the	S 479	Developed and reviewed Dietary Services, Food Safety and Procurement, and Written Menu policies and procedures. Re-educated dietary staff on Dietary Services, Food Safety and Procurement, and Written Menu's. Dietary Manager or designee. The Dietary Manager or designee will conduct weekly supervisory audits for 4 weeks, then monthly thereafter. Audit results will be reviewed by the QAPI Committee.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 479	Continued From page 27 reason for the substitution." *"The food service manager will review the substitutions regularly to avoid recurrences when possible."	S 479	A Self Administration of Medication policy was developed and reviewed. To ensure that residents who are capable may safely self-administer medications while protecting resident health, safety, and regulatory compliance. Park Place Assisted Living supports resident independence by permitting self-administration of medications when clinically appropriate and safe. Self-administration is allowed only after proper assessment, physician authorization, and ongoing monitoring. Residents may self-administer medications only with a physician order and documented nursing assessment. The interdisciplinary team will determine the level of supervision required. Medications approved for self-administration must be stored securely and separately from facility-stock medications.	1/18/2026
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 observation, interview, care record review, and policy review, the provider failed to ensure: *The resident's ability to safely self-administer medications was assessed quarterly for three of five sampled residents (1, 2, and 4), who self-administered medications. *Residents were supervised while taking their medication for four of four sampled residents (1,	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 28 2, 6, and 7) who were not assessed to self-administer those medications. *The physicians' orders accurately reflected the medication approved for self-administration for two of five sampled residents (2 and 4) who self-administer medications. Findings include: 1. Observation and interview on 12/2/25 at 3:25 p.m. with resident 2 regarding administration of medications revealed: *He was alone in his room and turned off his nebulizer machine (a device that converts liquid medication into an inhalable mist) as the surveyor entered his room. *He stated he self-administered all of his own medications when he was admitted to the facility; however, now he has the staff administer most of his medications. *The staff members set up his nebulizer treatments, and then he completes those nebulizer treatments independently. He kept his inhaler (a portable device for administering inhaled medication) and nitroglycerine (a fast-acting medication used to relieve or prevent episodes of chest pain) in his room for when he needed them. Review of resident 2's care record revealed: *He was admitted on 1/7/25. *His 1/15/25 Medication Self-Administration Safety Screen indicated "Staff to store, set-up and supervise administration of all medications. Resident can have [his] inhaler and nitroglycerine at bedside. Resident may self-administer nebulizer treatments after set-up." *There was no documentation that a Medication Self-Administration Safety Screen had been completed quarterly in April 2025, July 2025, or	S 685	Residents must demonstrate ongoing competency to continue self-administration. Nursing staff will assess the resident's cognitive status, physical ability, understanding of medications, and ability to recognize adverse effects. The assessment will be documented in the medical record. A physician order approving self-administration and identifying medications allowed must be obtained. Self-administration will be addressed in the resident's comprehensive care plan. The care plan will specify the level of supervision (independent, supervised, or assisted). Residents approved for self-administration will receive education on their medications.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 29 October 2025. *His 1/14/25 (Provider's name) Standing Orders indicated his physician had marked "Self-Administer medications after set-up." There was no indication which medications resident 2 was to self-administer. 2. Interview on 12/2/25 at 3:45 p.m. with resident 1 regarding administration of medications revealed: *She stated that she was not allowed to keep her medications in her room, but was unsure if prescription creams, eye drops, or mouthwash counted as medications. *She stated that staff members brought all of her "pills" to her and left them on the small table in her room, and that she knew when to take them. Review of resident 1's care record revealed: *She was admitted on 8/4/20. *Her 10/9/24 Medication Self-Administration Safety Screen indicated "Resident requires staff to store, set up, and administer all oral medications. Resident is able to store, set up, and administer eye drops, mouthwash, and creams." *There was no documentation that a Medication Self-Administration Safety Screen had been completed quarterly in January 2025, April 2025, July 2025, or October 2025. 3. Observation and interview on 12/3/25 at 7:15 a.m. with unlicensed assistive personnel during medication administration revealed: *UAP J prepared residents 6's morning medications in the workroom. She placed those medications in a small cup and brought them to resident 6 in the dining room. UAP J placed the small cup of medications she had prepared on the table in front of resident 6 and exited the	S 685	Nursing staff will receive training on assessment and monitoring requirements. Monitoring and Quality Assurance. Director of Nursing or designee. Conducted a facility-wide audit, for identified residents and all residents to ensure the self administration and medication policy is being followed and Care Plans are updated. Director of Nursing or designee. Self-administration practices will be reviewed through audits and incident reviews. Findings will be addressed through the Quality Assurance and Performance Improvement (QAPI) program.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 30 dining room. She did not observe resident 6 take those medications. *UAP J prepared resident 7's morning medications in the workroom. She placed those medications in a small cup and brought them to resident 7 in the dining room. UAP J placed the small cup of medications she had prepared on the table in front of resident 7 and exited the dining room. She did not observe resident 7 take those medications. *When asked, UAP stated that some residents required supervision when they took their medications, but that she did not need to remain with residents 6 or 7 when they took their medications. Review of resident 6's care record revealed there was no documentation that she was able to self-administer her medication or physician's order for medication self-administration. Review of resident 7's care record revealed there was no documentation that she was able to self-administer her medication or physician's order for medication self-administration. 4. Review of resident 4's care record revealed: *He had been admitted on 8/29/25. *There was no documentation that a physician's order was obtained for resident 4 to self-adminster his medications. *A self-administration of medication assessment had been completed on 8/29/25 by registered nurse (RN)/director of nursing (DON) B. -This identified each of the eight medications that he was able to take on his own without staff assistance. -All medications prescribed at the time of the assessment were listed on the assessment document.	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 31 *The medication, Jardiance (a medication used to lower blood sugar), was added on 11/26/25. *The quarterly self-adminstration of medication assessment was due on or around 11/29/25. *There was no documentation to support an updated self-administration of medication had been completed when it was due or to include the new medication that had been ordered. 5. Interview on 12/3/25 at 10:20 a.m. with UAP J regarding resident self-administration of medications revealed: *Resident 1 was not allowed to keep any medication in her room. She would prepare resident 1's medication and bring them to her room. Resident 1 had requested that her medications be left on the little table in her room. Resident 1 was good about taking those medications. *She provided resident 2 with most of his medications. She set up resident 2's nebulizer treatments, and he would administer them independently. She was aware that resident 2 kept an inhaler in his room, but was unaware if he kept nitroglycerine tablets in his room. *She knew what residents required supervision with taking their medications because there was a note in the computer system that indicated the resident required supervision to take their medications. 6. Interview on 12/3/25 at 11:26 a.m. with RN/case manager (CM) C and RN/DON B regarding resident self-administration of medications revealed: *The confirmed that residents 6 and 7 did not self-administer medications. *RN/CM C did not think that leaving resident 6 or 7's medications in front of them at the dining room table was considered self-administration of	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 32 medications. *RN/DON B expected UAPs to supervise residents 6 and 7 when they took their medications "until they swallowed the last pill." *RN/CM C confirmed that resident 1 did not self-administer medications. *RN/CM C confirmed that resident 2 self-administered some of his own medications, including an inhaler and his nebulizer treatments. *RN/CM C did not think that UAPs leaving residents' 1 or 2's medications in their room with them was considered self-administration. *RN/DON B expected UAPs to supervise residents who were not assessed to self-administer their medications "until they swallowed the last pill," in the dining room and in their own rooms. *RN/DON B expected UAPs to supervise residents who were not assessed to self-administer their medications while they completed their nebulizer treatments. *RN/DON B expected that only medications that a resident had been assessed to self-administer safely would remain in a resident's room. *Residents would be assessed quarterly to determine if they could self-administer medications and which medications they were safely able to self-administer. Some residents self-administered all of their medications, while other residents self-administered only specific medications. *RN/DON B expected that the quarterly medication self-administration assessments would include which medications a resident could safely self-administer and would be updated with any changes. *All self-administration of medications required a physician's order, and that order would indicate which medications a resident was able to self-administer.	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 33 7. Interview on 12/3/25 at 2:05 p.m. with administrator A revealed: *Resident 2 did not have an order to self-administer his nebulizers, inhaler, or nitroglycerine tablets so she requested an order from his physician. 8. Interview on 12/4/25 at 4:30 p.m. with RN/DON B and RN/CM C revealed resident 4 took all of his medications on his own and without staff assistance. 9. Review of the provider's revised 6/5/24 Self-Administration of Drugs policy revealed: *"Residents in our facility who wish to self-administer their medication may do so, if it is determined that they are capable of doing so by their physician." *"As part of their overall evaluation, the practitioner will assess each resident's mental and physical abilities to determine whether a resident is capable of self-administering medications." *"The staff or practitioner will document if the resident is potentially capable of self-administering medications." *"The staff or practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications." Review of the provider's revised 3/12/25 Medication Administration and Destruction policy revealed: *"Residents may self-administer medications under the supervision of a licensed nurse." *"A physician's order is required." *"An evaluation and education will be documented every 90 days or upon significant	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 685	Continued From page 34 change regarding the resident's wish to self-administer from bedside or self-administer after setup will be documented."	S 685	Reviewed the identified residents' admission records for completeness, including assessments, resident rights, consents, physician orders, and care plans. Completed any missing or incomplete admission documentation. Director of Nursing, Administrator, or designee. Conducted a facility-wide audit of all admissions to ensure all required admission elements were completed. Director of Nursing, Administrator, or designee. Corrected identified deficiencies and ensured interdisciplinary admission requirements were met. Developed and reviewed the Admission Policy to clarify required documentation, timelines, and staff responsibilities. Admission practices will be reviewed through audits following an admission, 30 days after an admission, and annually thereafter. Director of Nursing or designee. Findings will be addressed through the Quality Assurance and Performance Improvement (QAPI)	1/18/2026
S 775	44:70:09:02 Facility To Inform Resident Of Rights Prior to or at the time of admission, a facility shall inform the resident, both orally and in writing, of the resident's rights and of the rules governing the resident's conduct and responsibilities while living in the facility. The resident shall acknowledge in writing that the resident received the information. During the resident's stay the facility shall notify the resident, both orally and in writing, of any changes to the original information. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure an acknowledgement of receipt for a copy of the resident's rights had been signed and dated by one of five sampled residents (3) or their representatives. Findings include: 1. Review of resident 3's care record revealed: *She was admitted on 12/4/24. *There was no documentation that resident 3 or her representative had signed an acknowledgement that they had received a copy of the resident's rights prior to or at the time of her admission. 2. Interview on 12/3/25 at 11:26 a.m. with registered nurse (RN)/director of nursing (DON) B revealed: *She was unable to locate documentation in the electronic or paper care records that resident 3 or	S 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 775	Continued From page 35 her representative had signed an acknowledgement that they had received a copy of the resident's rights prior to or at the time of her admission. *The previous case manager was no longer employed since March 2025, and RN/DON B was aware that there had been some missing documentation. She was unaware that resident 3's acknowledgement of resident rights had been missing from the care record. 3. Interview on 12/4/25 at 4:15 p.m. with administrator A revealed: *There was no documentation that resident 3 had been educated on or had signed a copy acknowledging receipt of her rights when she was admitted to the facility. *It was the provider's regular process that the case manager would complete the acknowledgement of the resident's rights when the admission paperwork was completed. That paperwork was then uploaded into the electronic medical record. She thought that the documentation had been completed when resident 3 was admitted and had been misplaced. *The provider had a change in case management in March or April 2025, and she was aware that some documentation had not been filed appropriately.	S 775	Reviewed the identified residents' admission records for completeness, including assessments, resident rights, consents, physician orders, and care plans. Completed any missing or incomplete admission documentation. Director of Nursing, Administrator, or designee. Conducted a facility-wide audit of all admissions to ensure all required admission elements were completed. Director of Nursing, Administrator, or designee. Corrected identified deficiencies and ensured interdisciplinary admission requirements were met. Developed and reviewed the Admission Policy to clarify required documentation, timelines, and staff responsibilities. Admission practices will be reviewed through audits following an admission, 30 days after an admission, and annually thereafter.	1/18/2026
S 791	44:70:09:03 Facility To Provide Information A signed and dated admission agreement between the resident or the resident's legal representative and the facility must include information described in subdivisions (1) through (8), inclusive. The resident or resident's legal representative and the facility shall complete the admission agreement before or at the time of	S 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 791	Continued From page 36 admission and before the resident has made a commitment for payment for proposed or actual care. The agreement must be printed in a manner to ensure ease of reading by the resident prior to signing. Any change in the admission agreement must be signed and dated by the resident or the resident's legal representative as an addendum to the original agreement. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure a signed assisted living admission agreement had been completed and provided to one of five sampled residents (3). Findings include: 1. Review of resident 3's care record revealed: *She was admitted on 12/4/24. *There was no documentation that resident 3 or her representative had signed an admission agreement and received a copy prior to or at the time of her admission. 2. Interview on 12/3/25 at 11:26 a.m. with registered nurse (RN)/director of nursing (DON) B revealed: *She was unable to locate documentation in the electronic or paper care records that resident 3 or her representative had signed an admission agreement or that they had received a copy of that agreement prior to or at the time of her admission. *The previous case manager was no longer employed since March 2025, and RN/DON B was aware that there had been some missing documentation. She was unaware that resident 3's admission agreement had been missing from	S 791	Findings will be addressed through the Quality Assurance and Performance Improvement (QAPI) program. Reviewed the identified residents' admission records for completeness, including a signed Admissions Agreement. Completed any missing or incomplete admission documentation. Director of Nursing, Administrator, or designee. Conducted a facility-wide audit of all admissions to ensure all required admission elements were completed. Director of Nursing, Administrator, or designee. Corrected identified deficiencies and ensured interdisciplinary admission requirements were met. Developed and reviewed the Admission Policy to clarify required documentation, timelines, and staff responsibilities. Admission practices will be reviewed through audits following an admission, 30 days after an admission, and annually thereafter. Director of Nursing or designee.	1/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41209	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING	405 1ST AVE BROOKINGS, SD 57006

(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 791	Continued From page 37 the care record. 3. Interview on 12/4/25 at 4:15 p.m. with administrator A revealed: *There was no documentation that resident 3 had signed or received a copy of the admission agreement when she was admitted to the facility. *It was the provider's regular process that the case manager would complete the admission agreement with the resident and the resident representative on the day of admission. That paperwork was then uploaded into the electronic medical record. She thought that the documentation had been completed when resident 3 was admitted and had been misplaced. *The provider had a change in case management in March or April 2025, and she was aware that some documentation had not been filed appropriately.	S 791	Findings will be addressed through the Quality Assurance and Performance Improvement (QAPI)	1/18/2026