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
	80608	A. BUILDING: _____ B. WING _____	C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - BROOKINGS	900 20TH ST SOUTH 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 complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 12/9/25 through 12/10/25. The area surveyed was related to potential verbal and physical resident abuse by a staff member. Peaceful Pines Living Center - Brookings was found not in compliance with the following requirements: S032 and S838.	S 000		
S 032	44:70:01:07.01 Reports To The Department Of Human Services A facility shall report an event involving any reasonable cause to suspect abuse or neglect of any resident by any person within twenty-four hours of the discovery of the event orally or in writing to the Department of Human Services, to a law enforcement officer, or to the state's attorney of the county in which the facility is located. This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota (SD) Department of Health (DOH) facility reported incident (FRI) review, interview, and policy review, the provider failed to report to the SD Department of Human Services (DHS) and SD law enforcement allegations of physical and verbal abuse by one of one unlicensed medication assistant (UMA) C towards one of one sampled resident (1). Findings include: 1. Review of the provider's South Dakota Department of Health (SD DOH) facility reported	S 032	The Executive Director reported the incident to the Department of Health within 24 hours of its occurrence, and the employee involved was removed from the facility within 2 hours. The Executive Director also reported the incident to the Ombudsman Office on 11/26/2025 and subsequently to Dakota At Home on 12/11/2025. On 12/23/2025, the Executive Director reviewed the South Dakota Assisted Living regulations 44:70:01:07 "Reports to the Department" and 44:70:01:07.01 "Reports to the Department of Human Services, Law Enforcement, or State's Attorney". All suspected incidents of abuse or neglect will be reported to the Department of Health within 24 hours of discovery. In addition, the Director of Nursing, Executive Director, or their designee will submit a report to the Department of Human Services/Dakota at Home or local law enforcement within the same 24/hour timeframe.	12/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 12/27/2025

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S 032	Continued From page 1 incident (FRI) submitted on 11/23/25 at 10:30 a.m. revealed: *On Sunday, 11/23/25, caregiver E and unlicensed medication aide (UMA) D contacted assistant director of nursing (ADON) B regarding an "interaction" between UMA C and resident 1. *It was reported that UMA C became "upset with [resident 1], forcefully grabbed her arm, and pushed her into her chair in her room." *Resident 1 told caregiver E and UMA D about the incident "when they checked on her after [UMA C] left the unit." *Resident 1 "was crying, and stated that her right arm hurt and that [UMA C] had pushed her." *Earlier that morning (11/23/25), "staff also observed UMA C yelling at [resident 1] about her drooling." *ADON B contacted executive director (ED) A, who came to the facility to meet with resident 1's husband. *ED A met with resident 1's husband and "discussed an action plan." *"The case was found to be unsubstantiated. Law enforcement and Dakota At Home were not notified. The local Ombudsman [name] was notified. No additional staff were interviewed regarding the allegations. PCP [primary care provider] was notified." 2. Interview on 12/10/25 at 9:05 a.m. with ED A revealed: *UMA C no longer worked at the facility. *UMA C's employment at the facility had been terminated because of the investigation into the incident that had occurred with resident 1 on the morning of 11/23/25. The provider had a "zero tolerance" abuse and neglect policy. *ED A had not contacted SD DHS or SD law enforcement regarding the above-described allegations because, after viewing the video	S 032		

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S 032	Continued From page 2	S 032		

footage, she was "unable to see if UMA C had done anything" that required her to report.
*She was unaware that she was required to report the suspicion of abuse or neglect to those agencies.

3. Interview on 12/10/25 at 10:20 a.m. and again at 11:44 a.m. with resident 1's husband revealed:
*He had received a call from caregiver E before 9:30 a.m. on the morning of 11/23/25 from his wife's room because his wife was crying and requested that staff members contact him.
*ED A met him at the facility and discussed his concerns. He had been told that UMA C was being sent home and an investigation would follow.
*Caregiver E had stated to resident 1's husband that UMA C "crossed the line," and that resident 1 was very upset in her room, and was crying.
*He stated he would come to the facility right away and wanted management there even though it was a Sunday.
*He felt that the incident was considered "elder abuse" and was glad that UMA C no longer worked at the facility. He had been told that the incident had been reported to the SD DOH, but was "pissed" that the facility had not reported the incident to law enforcement or the SD Board of Nursing (BON). He had been told by ED A that he could report the incident to those agencies if he felt it was necessary. He was unaware whether the incident should have been reported to SD DHS.

4. Interview on 12/10/25 at 1:10 p.m. and review of the provider's Abuse and Neglect, Investigation and Reporting policy at 3:50 p.m. with ED A revealed:
*She had reason to suspect abuse had occurred after speaking with staff members who were

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S 032	Continued From page 3 present, speaking with resident 1 and her husband, and watching the video footage of the incident that occurred between UMA C and resident 1. *She had completed her investigation on 11/24/25 and determined that she could not substantiate whether abuse had occurred because there was no video footage of what had occurred in resident 1's room, and UMA C denied pushing the resident into her chair. *She was aware that resident 1's husband was upset that she had not contacted the SD BON and law enforcement. She had provided him with the contact information for the SD DOH, the local ombudsman, and DHS. She had told him that he could contact law enforcement and the SD BON if he had any further concerns. *She had reached out to the local ombudsman by email for guidance on how to proceed regarding her reporting responsibilities; however, she had not heard back from the ombudsman's office. *She felt the facility's abuse policy was vague and did not clearly indicate when she needed to report concerns regarding resident abuse or to whom she needed to report them. 5. Review of the providers updated 7/15/22 Abuse & Neglect, Investigation & Reporting policy revealed: *"Abuse- Intentional mistreatment that may cause either physical or psychological injury." *"The Administrator or Designee does the following: Reports alleged or suspected cases of abuse, neglect, misappropriation or exploitation to the appropriate authorities as soon as possible but not more than 48 hours after the incident is reported, according to law and regulation." *"Cases involving children, disabled adults, or the elderly must be reported to the state's Family and Protective Services agency or similar authority."	S 032		

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S 032	Continued From page 4 *"Collaborates with law enforcement or other agencies with investigations, as appropriate and according to law and regulation." 6. Review of the provider's undated Executive Director Job Description revealed: *Duties and Responsibilities to include: -"Is responsible for the well-being and protection of every resident ..." -"Is responsible to oversee that all services and business practices are being conducted according to State regulation." -"Preferred knowledgeable in Federal, State, and general health care related regulations ..."	S 032		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, interview, care record review, and policy review, the provider failed to ensure one of one sampled resident (1) was free from physical and verbal abuse and psychological harm from one of one employee (C) and that all residents had been assessed for possible risk of abuse.	S 838	The employee had no prior disciplinary actions, and the facility had no previous indication that the employee posed a risk to any resident. The employee was removed from the facility within 2 hours of the event. The facility will conduct an educational session on Abuse, Neglect, and Mandatory Reporting for all employees. This training will be completed no later than 01/24/2026. For employees that are unable to attend the training, a makeup binder will be created and the expectation is that they will complete it no later than 01/24/2026.	01/24/2026

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S 838	Continued From page 5 Findings include: 1. Review of the provider's South Dakota Department of Health (SD DOH) facility reported incident (FRI) submitted on 11/23/25 at 10:30 a.m. revealed: *On Sunday, 11/23/25, caregiver E and unlicensed medication aide (UMA) D contacted assistant director of nursing (ADON) B regarding an "interaction" between UMA C and resident 1. *It was reported that UMA C became "upset with [resident 1], forcefully grabbed her arm and pushed her into her chair in her room." *Resident 1 told caregiver E and UMA D about the incident "when they checked on her after [UMA C] left the unit." *Resident 1 was crying, and stated that her right arm hurt and that [UMA C] had pushed her. *Earlier that morning (11/23/25), staff also observed UMA C yelling at [resident 1] about her drooling. *Resident 1's husband was contacted, and he "immediately" came to the facility and requested to speak with management. *ADON B contacted executive director (ED) A, who came to the facility to meet with resident 1's husband. *ED A met with resident 1's husband and "discussed an action plan." -UMA C was sent home pending the results of an investigation. *ED A "joined [resident 1] in the dining room for lunch. Her behavior was abnormal she stared straight ahead without emotion." *ED A spoke with UMA C and "asked if she had any unfavorable interactions with [resident 1] that morning. [UMA C] denied the allegations, stating she was trying to protect other residents from [resident 1's] language and behavior." UMA C	S 838		

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S 838	Continued From page 6 denied pushing resident 1 into her chair or causing her to cry. *ED A informed UMA C that she "needed to clock out and go home pending investigation, emphasizing that this situation must be taken seriously as potential abuse/neglect." *"UPDATE as of 5:00 p.m. 11/24 [11/24/25] - employee [UMA C] is no longer employed with [provider name]." *"The case was found to be unsubstantiated. Law enforcement and Dakota At Home were not notified. The local Ombudsman [name] was notified. No additional staff were interviewed regarding the allegations. PCP [primary care provider] was notified." *There was no indication in the report: -That resident 1 had been assessed for injury. -Whether other residents had been identified as at risk for potential abuse or neglect. -If other residents or staff had been interviewed regarding interactions with UMA C. 2. Observation and interview on 12/9/25 at 1:53 p.m. on the memory care unit revealed: *The atmosphere was calm, and the four staff members present were attentive to the resident's needs. *Approximately nine residents were seated in the living room in an exercise class with a staff member. All residents were engaged in that activity. *Two male residents repeatedly engaged with staff members in conversation. Those conversations were calm and kind. The staff member, at times, provided redirection that indicated that the resident was confused. *Individual interviews with four residents revealed that all four residents reported they felt safe and were not fearful of staff yelling at them or hurting them.	S 838		

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S 838	Continued From page 7 *One resident reported that at times another resident would yell at staff, but was unable to identify who that resident was. 3. Interview on 12/9/25 at 2:00 p.m. with caregiver E and UMA F revealed: *They identified residents who demonstrated behaviors that included swearing, becoming verbally aggressive towards staff or other residents, wandering, and those who were considered an elopement risk. *They had been educated on how to respond to residents who demonstrated those behaviors and shared some strategies they used, including redirection, reapproaching when the residents were calm, asking a coworker for assistance, and offering snacks or favorite activities. *Caregiver E identified a situation that occurred between UMA C and resident 1 that was concerning to her. Caregiver E stated that she had witnessed UMA C become frustrated with resident 1. *Caregiver E stated that resident 1 had been sitting at the table after breakfast one day a couple of weeks ago and had gotten up from her chair, and UMA C "became a little physical" with resident 1 when she "wrapped her arm around [resident 1] and walked her very quickly" to her room. *UMA C had left the unit when she exited resident 1's room, and caregiver E and UMA D heard resident 1 crying in her room, and they went in to check on her. -Resident 1 was crying and very emotional. She stated that UMA C had pushed her into her chair and that she wanted to call her husband. *UMA D and caregiver E checked to make sure that resident 1 was ok, assisted her in calling her husband, and called ADON B to report what had happened.	S 838		

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S 838	Continued From page 8 *Resident 1's husband and ED A came to the facility right away, and UMA C was sent home and had not returned. *Caregiver E stated that UMA C, at times, had a "short temper." She had not seen UMA C become physically aggressive with any resident before that day. 4. Review of the resident 1's care record revealed: *She was admitted on 12/11/24. *Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities), major depressive disorder, anxiety disorder, and Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). *Her Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated her cognition was moderately impaired. *She required staff members to offer activities, encourage, and monitor her participation. *She had occasional behaviors that included crying, becoming agitated, and name-calling. 5. Interview on 12/10/25 at 9:05 a.m. with ED A revealed: *UMA C and UMA D no longer worked at the facility but had each provided a written statement. *UMA C's employment at the facility had been terminated because of the investigation into the incident with resident 1 that had occurred on the morning of 11/23/25. The provider had a "zero tolerance" abuse and neglect policy. *ED A had not contacted the Department of Human Services (DHS) or law enforcement regarding the above-described incident because, after viewing the video footage, she was "unable to see if UMA C had done anything" that required her to report.	S 838		

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S 838	Continued From page 9 *She was unaware that she was required to report the suspicion of abuse or neglect to those agencies. 6. Interview on 12/10 /25 at 10:10 a.m. with caregiver E revealed resident 1: -Had Parkinson's Disease and would at times "freeze" when she took her medications. -Walked slowly with a walker. -Was able to recall certain information, but often responded in simple phrases or with single words. -Was emotional and cried frequently. Staff members would often ask her if they were "happy tears, or sad tears." -Had preferred caregivers, including UMA F, whom resident 1 often asked for. 7. Interview on 12/10/25 at 10:15 a.m. with UMA F revealed: *UMA F had not been at the facility on 11/23/25 when the incident described above occurred between resident 1 and UMA C, but stated that resident 1 was very upset when she returned the following Monday, 11/24/25. *Resident 1 had an increase in behaviors of crying, swearing, having to call her husband frequently, and being afraid after 11/23/25 for about two weeks. UMA F stated that resident 1 seemed much calmer as of 12/10/25. *For several days after the incident between resident 1 and UMA C, resident 1 had grabbed her arm and repeated that UMA C had pushed her, but she had stopped talking about it within the past week. *UMA F had seen UMA C speak rudely to residents before, had intervened at those times, and reported those incidents in writing to ED A. She had not observed UMA C become physically aggressive with residents and described UMA C	S 838		

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S 838	Continued From page 10 as "grumpy" and "short-tempered." She felt that UMA C did not communicate well with the residents who lived in the memory care unit. 8. Interview on 12/10/25 at 10:20 a.m. and again at 11:44 a.m. with resident 1's husband revealed: *He had received a call from caregiver E before 9:30 a.m. on the morning of 11/23/25 from his wife's room because his wife was crying and requested that staff members call him. Caregiver E had stated UMA C "crossed the line," and that resident 1 was very upset in her room, crying. *He stated he would come to the facility right away and wanted management there even though it was a Sunday. *Caregiver E informed him that she had called him first to calm resident 1, and ADON B was being contacted. -He felt that caregiver E and UMA D had handled the situation professionally, and he was glad they had called him first to ensure resident 1 was safe. *ED A met him at the facility and discussed his concerns. He had been told UMA C was being sent home, and an investigation would occur. He was told it was a last straw for UMA C and that UMA C had been spoken to before. *He felt that the incident should have been prevented. *He stated that his wife was "very emotional," and would at times require frequent reassurance, would swear at staff members, and could get upset easily, but that in the days following the incident, she had been "scared" and "out of control." -He stated that resident 1 grabbed her arm and stated UMA C's name repeatedly "for days." -He typically visited his wife every other day, but there were days after the incident that his wife called, and he had to come to the facility three times to calm and reassure her.	S 838		

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S 838	Continued From page 11 *Resident 1's husband, daughter, and son had a meeting with ED A on 11/24/25 to discuss their concerns. *He felt that the incident was considered "elder abuse" and was glad that UMA C no longer worked at the facility. He had been told that the incident had been reported to the SD DOH, but was "pissed" that the facility had not reported the incident to law enforcement or the SD Board of Nursing (BON). He had been told that he could report the incident to those agencies if he felt it was necessary. *He was worried about retaliation and that his wife would be discharged from the facility because of the incident, but had "absolutely no other concerns" about the care that his wife received. He felt that she was safe and well cared for now that UMA C was no longer employed. He worried that when resident 1 required a higher level of care in a nursing home that UMA C might work there. 9. Interview and review of video footage on 12/10/25 at 10:29 a.m. with ED A revealed: *The video was of the dining room in the memory care unit. It was approximately 17 minutes long and did not contain audio. *At 9:10 a.m., resident 1 could be seen sitting at a table with another resident. There were six or seven other residents in the dining room, and 1 staff member, UMA C, can be seen cleaning tables. *At approximately 9:12 a.m., resident 1 got up from her chair, walked without her walker over to the male resident at the table to her right, and began feeding him with a utensil. Both residents appear calm. *At 9:13 a.m. UMA C quickly approached, grabbed resident 1's walker, grabbed resident 1 by her right arm, placed the walker in front of	S 838		

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S 838	Continued From page 12 resident 1, and walked her very quickly down the hallway towards her room, pulling her by her right arm. Resident 1 could be seen stumbling as she walked. *UMA C returns to the dining room less than one minute later. *At 9:14 a.m., resident 1 is seen returning to the dining room with her walker. She walked much more slowly, independently. At 9:14:34 a.m. UMA C is seen grabbing resident 1 by her left arm, very quickly spinning resident 1 around with her walker, and forcefully walking her back down the hallway towards her room. *At 9:17 a.m., UMA C returns to the dining room and exits the memory care unit. 10. Interview on 12/10/25 at 1:10 p.m. and review of the provider's Abuse and Neglect, Investigation and Reporting policy at 3:50 p.m. with ED A revealed: *ED A stated that UMA C's employment had been terminated because of actions seen in the video, and caregiver E, UMA D, and resident 1's reports of what had occurred on 11/23/25. *She had reason to suspect abuse had occurred after speaking with staff members who were present, resident 1 and her husband, and watching the video footage of the incident that occurred between UMA C and resident 1. *She had completed her investigation on 11/24/25 and determined that she could not substantiate whether abuse had occurred because there was no video footage of what had occurred in resident 1's room, and UMA C denied pushing the resident into her chair. *She had reached out to the local ombudsman by email for guidance on how to proceed regarding her reporting responsibilities; however, she had not heard back from the ombudsman's office. *UMA F had provided her with two written	S 838		

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	80608	A. BUILDING: _____ B. WING _____	C 12/10/2025

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S 838	Continued From page 13 concerns before 11/23/25 regarding UMA C's interactions with residents. -ED A had not reviewed video footage of those incidents because the reports were of verbal interactions, and the videos did not contain audio. -She had not done an investigation into those concerns reported by UMA F. UMA C had been provided with education and two verbal warnings regarding her "attitude." ED felt that UMA C's attitude "improved for a while" before a second verbal warning was provided. ED A had not documented those verbal warnings. *She felt the facility's abuse policy was vague and did not clearly indicate when she needed to report concerns regarding resident abuse or to whom she needed to report them. 11. Interview on 12/10/25 at 4:51 p.m. with caregiver G revealed: *She worked on 11/23/25 and had witnessed UMA C's interaction with resident 1 in the dining room. She had been assisting another resident and saw UMA C grab resident 1's arm and UMA C made resident 1 walk "very fast" back to her room. Caregiver G stated that resident 1 could not walk that fast on her own. *She heard resident 1 crying from the dining room, a short distance from resident 1's room, and as soon as UMA C left the memory care unit, caregiver E and UMA D went to resident 1's room to check on her. She thought that had been about one to two minutes after the incident occurred. *UMA D and caregiver E contacted ADON B, and ED A came to the facility a short time later. *She had not worked often with UMA C and had never seen UMA C become physical like she had on 11/23/25 with resident 1. She thought that UMA C was "grumpy" and "easily annoyed" with residents whom she cared for.	S 838		

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S 838	Continued From page 14 12. Review of a written statement provided by UMA C to ED A on 11/23/25 regarding the above observation revealed: *UMA C stated, "I put my arm underneath her, grabbed her walker and walked her quickly back to her room. When we go [got] to her room, I helped her sit in her chair and I sat down and asked [told] her you cannot talk to other residents that way, and that she should stay in her room until she has [had] calm[ed] down. I left the room ..." 13. Review of a written statement provided by UMA D and caregiver E to ED A on 11/23/25 regarding the above observation revealed: *The statement was signed by both UMA D and caregiver E. *On Sunday, 11/23/25, UMA C "grabbed her [resident 1] right arm and walker and dragged [resident 1] back to her room. The pace was too fast for [resident 1]." *"We heard [resident 1] start crying and scream two times. UMA C then left the room." *UMA D "then went to go check on [resident 1] because she was concerned." *They "immediately recognized this [UMA C's behavior] and knew it was extremely inappropriate and unacceptable." *Resident 1 "was crying and holding her right arm." She stated that her arm hurt. *Resident 1 told them UMA C "took her back to her room by tightly grabbing her arm then forcefully pushed her into her chair." 14. Review of a written statement provided by caregiver G on 11/24/25 regarding the above observation revealed she: *Witnessed UMA C grab resident 1 by the arm, and that UMA C "started pulling her into her room ..."	S 838		

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S 838	Continued From page 15 *Heard resident 1 "yelling/crying very loud in her room as [UMA C] was in there." *Was assisting another resident, and "my other two coworkers went to check up on [resident 1]." 15. Review of the written statements provided by UMA F to ED A regarding UMA C revealed: *On 8/5/25 at about 1:15 p.m., UMA C "got into an argument" with a resident in front of another resident's family. UMA C was "almost yelling" at that resident. The resident "was very upset afterwards." -UMA F intervened and offered assistance to UMA C and apologized to the resident and family for having witnessed UMA C's interaction. -The family stated that UMA C should have "handled [the situation] differently." *On 11/10/25, UMA C had posted "STAFF ONLY" signs at the nurses' station and "started to yell at" a resident who liked to wash his hands in the sink when he tried to enter that area. -UMA C then began to "yell at staff" that they needed to enforce that rule. 16. Review of the providers updated 7/15/22 Abuse & Neglect, Investigation & Reporting policy revealed: *"Abuse- Intentional mistreatment that may cause either physical or psychological injury." *"The Administrator or Designee does the following: Reports alleged or suspected cases of abuse, neglect, misappropriation or exploitation to the appropriate authorities as soon as possible but not more than 48 hours after the incident is reported, according to law and regulation." *"Cases involving children, disabled adults, or the elderly must be reported to the state's Family and Protective Services agency or similar authority." *"Collaborates with law enforcement or other agencies with investigations, as appropriate and	S 838		

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S 838	Continued From page 16 according to law and regulation."	S 838		