DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435083	A. BUILDING _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DR 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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/17/22 through 5/19/22. The Neighborhoods at Brookview was found not in compliance with the following requirements: F578, F604, F657, and F880. The Neighborhoods at Brookview's vaccination program was reviewed for compliance with the Centers for Medicare and Medicaid Quality, Safety and Oversight (QSO) memorandum QSO-22-09-ALL, dated January 14, 2022, from 5/17/22 through 5/19/22. The Neighborhoods at Brookview was found in compliance.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578	1. All residents have the potential to be at risk. 2. The nieghborhood nurse supervisors are currently addressing to ensure written/ signed documentation that identifies the following resident's code status is completed: 47, 53,49,54, 68,30. All other residents' documentation will also be reviewed. A newly developed code status written documentation sheet will be utilized to have written/signed documentation regarding individual code status choice. No corrective action is necessary for resident 41 as they have passed away. Going foward the admitting nurse will ensure code status is received and reviewed. DON or designee will provide education to residents during the next scheduled resident council meeting (6/21/22) regarding the resident right of "the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, an to formulate an advanced directive." Residents will be updated on newly developed code status documenation paperwork. DON or designee will provide education to the Interdisciplinary Care Plan Team (including Household Coordinators, Social Worker, Nurse Supervisors) in regards to newly developed code status written documentation, along with the need to review Advance Directives/Code status upon admission, at	6/18/22

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

Jeremy Klinkhammer

TITLE: Administrator

(X6) DATE: 6/22/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure advance directives were current for seven of seven sampled residents (30, 41, 47, 49, 53, 54, and 68). Findings include. 1. Review of resident 47's electronic medical record revealed: *He had a 9/3/20 signed power of attorney (POA) form that stated: -"I desire that cardiopulmonary resuscitation (CPR) be used only when there is a good chance that the use of such a procedure shall result in a full recovery..." *Admission paperwork on 10/16/21 from the hospital stated: -"CODE STATUS is switched to DNR [do not	F 578	least quaterly and PRN. Care Planning Procedure updated to include the following: "Upon admission and at least quarterly and PRN the residents and/or their representative shall discuss with the staff Advance Directives, including code status. Documentation will be found in the EMR and/or the residents paper chart." 3. DON or designee will complete 5 random resident EMR's and paper chart audits per week for 4 weeks, then monthly for 4 months. DON or designee will bring the results of the audits to the QAPI meeting for further review and recommendation to contiue or discontinue.	

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F 578	Continued From page 2	F 578		

resuscitate] after reviewing paperwork from [assisted living facility's name]. He is a DNR/DNI [do not intubate] per their paperwork."

2. Review of resident 53's electronic medical record revealed:
*She was under guardianship.
*The guardianship documentation had not addressed her code status.

Interview on 5/19/22 at 10:35 a.m. with registered nurse (RN) unit manager E regarding residents 47 and 53's advance directive revealed:
*The social worker (SW) C has all of the resident's code status' and advance directives.
*The information is gone over at care conferences.

Interview on 5/19/22 at 11:02 a.m. with Social Worker (SW) C revealed:
*Code statuses and advance directives are handled by the nurses.
*She obtains living wills and POAs upon admission, otherwise nursing goes over the information at care conferences.
*They do not have a period in which they update code statuses or advance directives.
*Resident 47 was a DNR according to his medical record.
*Surveyors informed her his POA form stated he wanted to be of full code status and asked when it had changed.
*She had been unable to find any documentation related to education regarding code status or when it may have changed.

Interview on 5/19/22 at 1:35 p.m. with SW C regarding resident 53 revealed:
*The guardianship paper was all they had for an

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F 578	Continued From page 3	F 578		

advance directive/code status.
*She agreed that the paper had not addressed code status or advance directive for resident 53, it was only for financial topics.

3. Review of resident 49's electronic and paper medical record revealed:
*She had been admitted on 4/13/18.
*Her Brief Interview for Mental Status (BIMS) had been fifteen. That score indicated she had no cognitive impairment.
*Her diagnoses included depression.
*There had been a 2/24/20 physician's order that listed her code status as DNR.
*There had been no signed documentation that identified her choice for her code status.

4. Review of resident 54's electronic and paper medical record revealed:
*She had been admitted on 2/3/16.
*Her BIMS had been twelve. That score indicated she had mild cognitive impairment.
*Her diagnoses included coronary artery disease and status post-stroke.
*There had been a 2/24/20 physician's order that listed her code status as DNR.
*There had been no signed documentation that identified her choice for her code status.

5. Review of resident 68's electronic and paper medical record revealed:
*She had been admitted on 11/13/15.
*Her BIMS had been fifteen. That score indicated she had no cognitive impairment.
*Her diagnoses included multiple sclerosis and schizophrenia.
*There had been a 4/29/21 physician's order that listed her code status as DNR.
*Had a living will dated 2/25/20 as full code which

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F 578	Continued From page 4 had been signed 12/2/04. 6. Review of resident 30's electronic medical record revealed: *She had been admitted on 1/8/21. *Her BIMS had been nine. That score indicated she had moderate cognitive impairment. *Her diagnoses included multiple sclerosis and dementia. *There had been a 9/9/21 physician's order that listed her code status as DNR. *There had been no signed documentation that identified her choice for her code status. 7. Review of resident 41's electronic medical record revealed: *She had admitted on 4/22/21. *Her BIMS had been fifteen. That score indicated she was cognitively intact. *Her diagnoses included: hypertension, chronic kidney disease, heart failure, chronic respiratory failure, and chronic obstructive pulmonary disease. *There had been a 4/22/21 physician's order that listed her code status as DNR. *There had been no signed documentation that identified her choice for her code status.	F 578	1. All residents have the potential to be affected. 2. No corrective action is necessary as resident 47 has had their wanderguard/code alert removed. Elopement Procedure updated to reflect "A physician order/diagnosis should be obtained for the code alert device to be applied and removed." Residents who need or utilize the Wanderguard device will have thorough documentation in the EMR to reflect the need for the device prior to obtaining the physician order for the device. DON or designee will provide education to all staff regarding the updated Elopement Procedure and current Restraint Policy.	6/18/22
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604	3. DON or designee will audit 5 random resident EMR, paper chart and care plans per week for 4 weeks, then monthly for 3 months to ensure that Elopement Risk Score/documentation is completed, potential Restraint/Mobility Device Evaluation documentation is completed, Medication Provider order is obtained and care plans are comprehensive to include an elopement risk with code alert/wanderguard utilized. DON or designee will bring the results of the audits to the QAPI meeting for further review and recommendation to continue or discontinue.	

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F 604	Continued From page 5 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (47) had been appropriately assessed and documented to indicate the use of the WanderGuard as a restrictive or enabling device. Findings include: 1. Observation and interview on 5/17/22 at 3:25 p.m. with resident 47 revealed: *He was sitting in a recliner in his room. *His feet had been propped up on his walker. *There was a WanderGuard bracelet attached to his walker. *Throughout the interview he was able to answer questions but seemed confused.	F 604		

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F 604	Continued From page 6	F 604		

Review of resident 47's electronic medical record revealed:
*He had been admitted to the facility on 10/18/21.
*He had a WanderGuard on his walker due to exit-seeking and elopement.
*The device had been placed approximately three weeks after he first arrived at the facility.
*He had elopement assessments completed and he had been always determined to be at no risk for elopement.
*There was no physician acknowledgement or order documentation for the use of the WanderGuard.

Interview on 5/19/22 at 10:35 a.m. with registered nurse (RN) unit manager E revealed:
*The WanderGuard had been placed because resident 47 had situations of exit-seeking events.
*She stated there was an audible alarm heard if the resident went near an exit door or the entrance to the unit.
*She stated the alarm had deterred the resident from wandering.
*When he heard the alarm going off, he had said "Oh, I guess I am not supposed to be going over there."
*They had not done an assessment for the device.
*She agreed he had not been marked to be at risk for elopement.
*Had not talked to the physician regarding the device.

Review of resident 47's physical therapy notes revealed:
*He had an issue with his neck.
*He often walked with his head down.
*Therapy believed he may have seemed like he was lost but he was unable to see as well

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F 604	Continued From page 7 because he had to walk with his head down and was still getting acclimated to his new home. Review of the provider's August 2012 Restraint Use policy revealed: *"The facility creates and maintains a homelike environment that emphasizes alternative/minimal restraint use while progressing towards achieving a restraint-free environment." *"The system is utilized until the goal is achieved, recognized and protects residents rights and when used, restraints are safe and appropriate for each resident based on agreed plan of care." *"The goal of this policy is for each person to attain and maintain his/her highest practical well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints." *"Each resident has the right to freedom from chemical and physical restraints. except as authorized in writing by a physician. The use of restraints is prohibited except to treat a medical symptom. Restraints will be used only as a last resort, not to be used to limit mobility for convenience of staff, for discipline, or as a substitute for supervision."	F 604		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657	1. All residents have the potential to be affected. 2. No corrective action is necessary as resident 47 has had their wanderguard/code alert removed. Nurse supervisors have reviewed and revised the care plans of resident 47 and 53 and all current residents individualized care plans to include their code status listed under the Advanced Directives Intervention. DON or designee will provide education to all staff in relation to the care plan procedure. 3. DON or designee will audit 5 random resident care plans per week for 4 weeks, monthly for 3 months to ensure that resident care plans are comprehensive and include wanderguard/code alerts and Advanced Directives. DON or designee will bring the results of the audits to the QAPI meeting for further review and recommendation to continue or discontinue.	6/18/22

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F 657	Continued From page 8	F 657		

(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to ensure:
*One of one sampled resident's (47) care plan had been updated to include the addition of a WanderGuard.
*Two of two residents (47 and 53) advance directives had been updated on their care plans.
Findings include:

1. Review of resident 47's 5/19/22 care plan revealed the use of a WanderGuard had not been mentioned or included. Refer to F604.

2. Review of resident 47's 5/19/22 care plan regarding his advance directive revealed:
*"Advance Directive."
-"I have a DPOA [directive power of attorney]

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F 657	Continued From page 9 document that names my daughter, [daughter's name] in my POA [power of attorney]. I have no specific healthcare preferences listed in my DPOA document." *There was no code status included in his care plan. Refer to F578. 3. Review of resident 53's 5/19/22 care plan revealed: *"Advance directive:" -"My son, [son's name], is my guardian and conservator He is able to assist with my finances and decision making as needed." *There was no code status included in her care plan. Refer to F578, finding 2. Interview on 5/19/22 at 10:35 a.m. with registered nurse (RN) unit manager E revealed: *They did not update care plans regarding code status. *Agreed resident 47's WanderGuard had not been placed on his care plan. Review of the provider's February 2013 Care Planning policy revealed: *"A comprehensive care plan must be prepared by an interdisciplinary team (ex: Food Service Worker, CNA [certified nursing assistant], Household Coordinators/Social Services Designee, etc.) that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs. and, the extent practicable, the participation of the resident, the resident's family or the resident's resident representative." *"The comprehensive care plan must be periodically reviewed and revised by a team of qualified persons as a resident condition	F 657		

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F 657	Continued From page 10 changes."	F 657		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880	1. All residents, staff, and visitors have the potential to be affected. 2. Infection Preventionist is addressing: Infection Control practices for five of twenty-three residents on Ash Boulevard and Maple Grove, informing staff and visitors of the current outbreak status in the facility, quarantine for two of two unvaccinated residents during a facility outbreak, quarantine for residents potentially exposed to COVID-19, education for all staff on proper PPE usage within quarantined areas, disinfecting medical equipment after use on quarantined residents, appropriate hand hygiene and glove use by licensed staff in quarantined areas. The Administrator, Director of Nursing (DON), Infection Preventionist (IP), and Staff Development Coordinator (SDC) will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be re-educated by the Administrator, DON, IP, and/or SDC. 3. The Administrator or designee will audit basic infection prevention concepts, PPE, hand hygiene and glove use and COVID-19 concepts. Administrator or designee will bring the results of the audits to the QAPI meeting for further review and recommendation to continue or discontinue.	6/18/22

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F 880	Continued From page 11 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection control practices were followed for the coronavirus (COVID-19) pandemic related to: *Infection control practices for five of twenty-three residents who reside on two separate units Ash Boulevard and Maple Grove within the same	F 880	Directed POC: *Infection Control practices for five of twenty-three residents on Ash Boulevard and Maple Grove *Informing staff and visitors of the current outbreak status in the facility *Quarantine for two of two unvaccinated residents during a facility outbreak *Quarantine for residents potentially exposed to COVID-19 *Education for all staff on proper PPE usage within quarantined areas *Not disinfecting medical equipment after use on quarantined residents *Appropriate hand hygiene and glove use by licensed staff in quarantined areas The Administrator, Director of Nursing (DON), Infection Preventionist (IP), and Staff Development Coordinator (SDC) will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or a responsible for the above cares and services will be re-educated by the Administrator, DON, IP, and/or SDC. Auditing and monitoring of the corrections will be completed as described below. Auditing and Monitoring Outline • After submission of Directed Plan of Correction (DPoc) and acceptance by Department of Health (DOH), the Administrator and IP will conduct a Root Cause Analysis (RCA) found here: https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf • After RCA is and DC accepted by DOH, Administrator and IP will also communicate any system changes to the South Dakota Quality Improvement Organization (QIO).Surveillance will be conducted as following:	

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	435083	A. BUILDING _____ B. WING _____	05/19/2022

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F 880	Continued From page 12 neighborhood. (5, 17, 22, 33, and 71) to prevent exposure and potential spread of COVID-19. *Informing staff and visitors of the current outbreak status in the facility. *Two of two nutrition and food service (NFS) employees (L and M) had been educated on proper infection control precautions and had not been working while sick. *Changing N95 masks after exiting two of two COVID-19 quarantined units (Ash Boulevard and Maple Grove). *Two of two certified nurse aides (CNA) F and G while providing fresh drinking water. *Providing appropriate personal protective equipment (PPE) donning (putting on) and doffing (removing) stations outside the quarantined areas. *Quarantine for two of two unvaccinated residents (46 and 64) during a facility outbreak. *Quarantine for potentially COVID-19 exposed residents. *Education for all staff on proper PPE usage within quarantined areas. *One of one CNA H disinfecting medical equipment after use on three of three observed (5, 17, and 30) quarantined residents. *One of one CNA H removing soiled gloves and performing hand hygiene after contact with three of three observed (5, 17, and 30) quarantined residents. Findings include: 1. Observations and interviews on 5/17/22 from 9:11 a.m. through 10:42 a.m. of NFS staff L and M in the Maple Grove neighborhood revealed: *At 9:11 a.m., NFS L's face mask was below her nose while she was standing at the dining area island. *At 9:50 a.m., her face mask was below her nose,	F 880	The Administrator, DON, IP, and/or the SDC will conduct auditing and monitoring two to three times weekly for four weeks, over all three shifts, to ensure identified staff and assigned tasks are being performed as re-educated and trained. Next, the Administrator, DON, IP, and/or the SDC will conduct auditing and monitoring two times monthly for one month, over all three shifts, to ensure identified staff and assigned tasks are being performed as re-educated and trained. Finally, the Administrator, DON, IP, and/or the SDC will conduct auditing and monitoring one time monthly (or more) for two months, over all three shifts, to ensure identified staff and assigned tasks are being performed as re-educated and trained. All surveillance and monitoring results will be reported during the Quality Assurance Performance Improvement (QAPI) meetings. Any findings of staff non-compliance will be discussed with the Administrator and appropriate Supervisor. Re-education and continued monitoring will occur for any non-compliance. Repeated non-compliance after appropriate re-education may result in staff corrective action.	

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F 880	Continued From page 13 and she coughed while she walked behind resident 22 who was seated at a dining room table. *At 10:03 a.m., NFS L walked up to resident 22, coughed as she pulled her mask up over her nose, and asked what resident 22 wanted for breakfast. *At 10:22 a.m., her mask was below her nose as she pushed resident 22 in his wheelchair away from the dining area. *At 10:34 a.m., NFS M's face mask was below her nose while she washed dishes in the kitchen. *At 10:42 a.m., NFS M reported she did not know if she was supposed to wear "goggles" (eye protection) when they were working in the kitchen. "Every time this comes up (a quarantine), we all don't know what we are supposed to wear," and her manager doesn't know. NFS M's face mask was missing the top strap so it did not fit tight over her nose. *At 10:38 a.m., NFS L reported she had her mask below her nose because she could not breath, she was "getting over a cold," and she was "going to get a note from her doctor so she doesn't have to wear it." 2. Observation on 5/17/22 at 9:58 a.m. of the facility's front entrance revealed: *Receptionist A sitting at the front desk with a surgical mask that was sitting underneath her nose. -She was not wearing any eye protection. *Approximately less than four feet away was an unidentified male who was seated in a wheelchair not wearing a mask and talking with receptionist A. 3. Interview on 5/17/22 at 10:49 a.m. with director of nursing (DON) D revealed:	F 880		

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F 880	Continued From page 14 *The facility had one COVID-19 positive resident. *They had no residents who were being quarantined. *They had two staff members who had tested positive for COVID-19 on 5/15/22 and 5/16/22. Continued observation on 5/17/22 at 1:21 p.m. revealed receptionist A was: *Wearing a surgical mask that had been pulled down underneath her nose. *Not wearing any eyewear protection. Interview on 5/18/22 at 9:16 a.m. with infection preventionist K revealed: *The facility had two COVID-19 positive residents on two different units, but within the same neighborhood. *She had been informed of the positive case via text message on 5/16/22 from DON D. Observation and interview on 5/18/22 at 1:37 p.m. in the "Towne Center" with infection preventionist K revealed: *She was wearing a surgical mask. *She was not wearing eye protection. *There were four positive COVID-19 residents at that point on two units (Ash and Maple units). -She stated Ash Boulevard and Maple Grove units were considered quarantine units. --Both units had potential exposure due to having huddled together into a small interior room because of a tornado warning on 5/12/22 . *An email was sent to the facility's "All Staff Email List" on 5/16/22 informing staff about the positive cases. *She confirmed that two staff members had tested positive for COVID-19. *She stated when there was more than one positive COVID-19 resident, those resident's units	F 880		

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F 880	Continued From page 15 were considered under quarantine and communal dining stops for the entire building. *She indicated the facility's PPE supply was adequate and they were to be using disposable aprons/gowns. *She confirmed that staff and visitors should have been: -Disposing of their face mask after exiting the quarantined units. -Sanitizing/disinfecting their goggles, face shields, or other eye protection after exiting the quarantined units. *She indicated the resident's doors on the quarantined units should have been shut unless the resident had safety concerns. 4. Observation and interview on 5/18/22 from 2:46 p.m. through 3:06 p.m. of the Ash Boulevard and Maple Grove units revealed: *People coming and going had to enter through a double door. *There were no signs indicating the area was quarantined and what precautions needed to be taken. *There were no PPE changing/sanitation stations set-up. *Upon entering through the double doors, there was hand sanitizer. -PPE stations were set-up outside of the COVID-19 positive residents' rooms. -The stations contained gloves and N95 masks. *At 2:51 p.m. administrator B walked into Ash Boulevard wearing an N95 mask and no eye protection. -He left Ash Boulevard wearing the same N95 mask. *At 2:52 p.m. NFS O exited the Ash Boulevard unit service kitchen, pushing a cart, headed toward the facility kitchen.	F 880		

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F 880	Continued From page 16 -She was wearing a surgical mask and no faceshield, stating she could not wear an N95 because of medical reasons. *At 3:01 p.m. CNAs F and G walked into Ash Boulevard with only surgical masks and goggles. *At 3:06 p.m. an unidentified employee left Maple Grove without changing or sanitizing her PPE. -She exited the unit without changing her mask or performing hand hygiene. 5. Observation and interview with 5/18/22 at 3:16 p.m. with CNA H and quarantine resident 30 revealed CNA H had: *Put on new pair of gloves before entering resident 30's room. *Entered resident 30's room and the door remained opened. *Placed her clipboard and paper on the resident's bedside table, next to her water cup. *Measured her vitals with a pulse oximeter and a digital forehead thermometer. *Exited the room wearing the same gloves and went into the nurse's station. *She went back into resident 30's room wearing the same gloves. *Her clipboard with paper and pen remained on the resident's bedside table next to her water cup. *Grabbed her clipboard and medical equipment and had begun to exit resident 30's room. *Not removed her soiled gloves and performed hand hygiene. *Not cleaned, disinfected, or sanitized the medical equipment. *The door remained open throughout the entire observation. Further observation and interview on 5/18/22 at 5:22 p.m. with CNA H and residents 5 and 17, who were quarantined revealed she:	F 880		

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F 880	Continued From page 17 *Walked down the hallway and entered resident 5's room with the same soiled gloves and soiled pulse oximeter and thermometer. -Resident 5's door had remained open. *Walked into resident 5's bathroom and asked if she could obtain their vitals. *Took resident 5's vitals and left the bathroom and room with the same soiled gloves, soiled clipboard, and soiled equipment. *Had not changed her gloves, or disinfected the medical equipment prior to entering resident 17's room. *Then exited resident 17's opened door wearing the same soiled gloves and carrying equipment she had used on residents 30, 5, and 17. -Surveyors observed she was not wearing her N95 mask appropriately as there were visible gaps around her nose and the straps were placed together on the back of her head. *Surveyor inquiry confirmed she had: -Not put on new gloves before entering a new resident's room, she never does. -Not sanitized the pulse oximeter or thermometer before entering a new resident's room. -Revealed the residents were staying in their rooms because of COVID-19. -Measured the vitals on residents first that had not been confirmed positive for COVID-19, then measured vitals on the residents that had tested positive last. -Not known how to wear her N95 mask correctly. -Not known if she had been fit-tested for wearing an N95. -Changed her PPE and cleaned medical equipment after being in the COVID-19 positive rooms. -Not known which residents should have been on isolation and which residents should have been quarantined.	F 880		

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F 880	Continued From page 18	F 880		

6. Observation and interview on 5/18/22 at 3:27 p.m. with CNA F and G revealed they:
*Were both wearing gloves while pushing a cart with water cups.
*Had not change gloves before entering another resident's room.

7. Interview on 5/18/22 at 3:34 p.m. with licensed practical nurse (LPN) J revealed:
*She was the charge nurse for the Maple Grove and Ash Boulevard units.
*There were two confirmed COVID-19 resident cases on Ash and two confirmed cases on Maple.
-Everyone else on the unit should have been quarantined.
*She considered the residents positive for COVID-19 to be "quarantined."
*Staff members were screening residents for symptoms of COVID-19 three times per day.
*All residents had been tested for COVID-19 that morning.
*Staff members were to:
-Remove their masks upon leaving the "isolation" COVID-19 positive rooms.
-Put on a new mask.
*She confirmed that staff do not put on disposable gowns/aprons, or change their N95 masks in between resident's rooms who were not confirmed cases of COVID-19.
*She stated they put a new N95 mask on when arriving at work and do not change it after contact with quarantined residents.

8. Interview on 5/18/22 at 3:52 p.m. with infection preventionist (K) revealed she:
*Had not been back on the COVID-19 units to watch infection control practices or check the set up of units.

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F 880	Continued From page 19 -She had been busy with the survey and had been at the hospital. *In regards to observations of administrator B and social worker (SW) C, she: -Believed from a microbiology standpoint it was highly unlikely that any COVID-19 germs spread by wearing the same N95 into other areas of the building. -Agreed there was still a risk of contamination. -Agreed it could confuse staff about what precautions to take and when to wear their N95 mask. *Stated the unit manager of Ash and Maple made the decision to not implement gowns for quarantined residents because, she: -Was worried staff would not use them appropriately with surveyors in the building. *Stated staff clean off their goggles or face shields but they do not change their N95 mask. -When asked if they follow centers for disease control and prevention (CDC) guidance, she stated "yes." 9. Observation on 5/19/22 at 9:25 a.m. of the Pine dining room revealed: *Unvaccinated residents 46 and 64 were eating breakfast in the communal dining room. *They were sitting at a table with four other residents. *There were other unidentified residents in the dining room as well. 10. Observation on 5/19/22 at 9:49 a.m. revealed unvaccinated resident 46 had been sitting in a chair in the "Towne Center." Review of facility email from nursing supervisor N on 5/16/22 at 3:10 p.m. revealed: *Steps for residents on isolation precautions.	F 880		

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F 880	Continued From page 20	F 880		

*All staff should have worn gowns, gloves, goggles, and N95 face masks before entering the isolation rooms.
*There was no mention of any quarantine precautions.

11. Review of the provider's July 2020 Infection Control Practices-A COVID-19 Addendum for the (provider's name] revealed:
*"All employees must refer to the [provider name] Infection Control Program in addition to this document. Standard precautions, including universal masking and wearing eye protection, must be used on all residents regardless of diagnosis or presumed infection status..."
*The following steps would be taken for a resident suspected or known to have COVID-19, which included:
-"Open dining and small activities may continue once neighborhood has had initial testing and all are negative. This may be subject to change if the situation warrants an entire quarantine."
-"ALL UNVACCINATED RESIDENTS on an affected neighborhood may need to quarantine depending on results of in-house contact tracing. REGARDLESS of viral testing."
-"All vaccinated residents on an affected neighborhood should wear masks depending on results of in-house contact tracing."
-"Removal from isolation or quarantine will be based on signs/symptoms, along with consultation from the IP [infection preventionist], Medical Director, DON, and/or DOH [department of health]."
-"If the resident is in quarantine/isolation, visitors may be required to additionally wear gloves, gown, and eye protection..."
*If two or more residents from different neighborhoods were suspected or known to have

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F 880	Continued From page 21 COVID-19, the following would happen: -"ALL UNVACCINATED RESIDENTS in the facility will quarantine regardless of viral testing." *Infection prevention considerations included: -"Limit only essential personnel to enter the room with appropriate PPE and bundle care as needed. PPE includes: Gloves, gowns, and respiratory protection (N95 or PAPR)." -"Follow the recommended donning and doffing instructions." -"Dedicated or disposable patient-care equipment should be used for residents on quarantine or isolation. If equipment must be used for more that one resident, it will be cleaned and disinfected before use on another resident."	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 5/17/22 through 5/19/22. The Neighborhoods at Brookview was found not in compliance with the following requirement: E004.	E 000		
E 004 SS=E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004	1. All residents have the potential to be affected. 2. Administrator will update all policies and procedures in the emergency preparedness plan, will review and update the evacuation plan, the emergency shelter for Brookings, transportation agreement, the memorandums of understanding for the provision of substance needs. Phone lists will be updated and reviewed. A communication plan for residents' physicians, volunteers to help with emergency shortages, and lists of other providers who would be available to assist during the emergency will be developed. A list of contacts for regional, state or federal emergency preparedness officals and communication agreement will be added. Ensure annual testing is completed, and put in the emergency preparedness plan. 3. Administator or designee will audit monthly for 4 months. Administrator or designee will bring the audit results to QAPI for further review and recommendation to continue or discontinue.	6/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremy Klinkhammer | TITLE: Administrator | (X6) DATE: 6/22/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review, the provider failed to annually maintain a comprehensive emergency preparedness (EP) program. Findings include: 1. Review of the provider's EP policy and procedure manual revealed: *The policies and procedures for all of the emergency events in the manual had last been reviewed either July 2020 or February 2021. *The Facility Assessment policy and procedure had last been reviewed July 2020. *The evacuation agreement between the provider and another provider was signed and dated July and October 2017. *The agreement for the provider to act as an emergency shelter for Brookings was signed and dated November and December 2011. *A transportation agreement was dated September 2017. *The memorandums of understanding for the	E 004		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435083	A. BUILDING _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DR BROOKINGS, SD 57006

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E 004	Continued From page 2 provision of subsistence needs was dated in 2015 or 2017. *Local community telephone numbers were dated 2015 and the staff phone list was not dated. *There was no communication plan with residents' physicians, volunteers to help with emergency shortages, and lists of other providers who would be available to assist during the emergency. *There was no list of contacts for regional, state, or federal emergency preparedness officials nor a communication plan with those officials. *There were no policies and procedures describing the medical documentation system for sharing, preserving, protecting, and maintaining the availability of records during an emergency event. *There was no documented annual testing using exercises or drills of the EP procedures since September 2020. Interview on 5/19/22 at 3:30 p.m. with administrator B confirmed the EP program had no updates from the above listed items.	E 004		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435083	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DR BROOKINGS, SD 57006

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/17/22. The Neighborhoods At Brookview was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321 and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	1. Residents on Ash have the potential to be affected. 2. Area will be cleaned of the items that are combustible and will be reorganized to ensure that the area is within code while also allowing resident to have a quality of life that will assist her in doing what she enjoys. The items that resident has on the table will be stored in resident room when not in use. Education was provided to resident on the reason for the change and also given to the Maple/Ash Nurse Supervisor on the plan going forward with her sewing area. 3. Administrator or designee will audit area 2 times a week for 4 weeks and then monthly for 3 months. The Adminstrator or designee will bring the audits to QAPI meeting for further review and recommendation to continue or discontinue.	6/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremy Klinkhammer
TITLE: Administrator
(X6) DATE: 6/13/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435083	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	**2421 YORKSHIRE DR 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) COMPLETION DATE
K 321	Continued From page 1 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to ensure all combustible storage spaces were protected by a fire barrier having 1-hour fire-resistance rating as required at one randomly observed location (Ash neighborhood). Findings include: 1. Observation beginning on 5/17/22 at 11:22 a.m. revealed a storage space in the dead-end of the west corridor in Ash. That storage space contained a significant number of combustibles (tables, fabrics, and other supplies for sewing) and was open to the corridor system. That storage space was greater than fifty square feet and was not enclosed with a 1-hour fire resistance rated enclosure. Interview with the maintenance director at the time of the observation confirmed that finding, He stated he was unaware the storage in that location created a problem. The deficiency affected one of numerous requirements for combustible storage and had the potential to affect 100% of the occupants of the smoke compartment B. Based on observation and interview, the provider failed to maintain one randomly	K 321		

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	435083	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	**2421 YORKSHIRE DR BROOKINGS, SD 57006**

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K 321	Continued From page 2 observed hazardous areas (bulk oxygen storage room) as required. Findings include: 1. Observation on 5/17/22 at 1:28 p.m. revealed the door to the bulk oxygen storage room in the service wing was striking the doorframe when closing. Testing of that door revealed it was equipped with a closer but would not latch into the frame automatically as required. Interview with the maintenance director at the time of the observation confirmed that finding, He stated he was unaware that door was not latching. The deficiency affected one of numerous requirements for oxygen storage room and had the potential to affect 100% of the occupants of the smoke compartment. Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that door was not latching. The deficiency affected one of numerous requirements for oxygen storage room and had the potential to affect 100% of the occupants of the smoke compartment.	K 321	1. Occupants of the smoke compartment have the potential to be affected. 2. Door frame will be adjusted to ensure compliance with closing properly. Doors will be on the preventative maintenance log going forward. 3. Adminsistrator or designee will audit doors weekly for 4 weeks and then monthly for 3 months. Administrator or designee will bring the results of the audits to QAPI for reveiw and further recommendations to continue or discontinue.	6/24/22
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363	1. Occupants of the smoke compartment have the potential for harm. 2. Door frame will be adjusted to ensure compliance with closing properly. Doors will be on the preventative maintenance log going forward. 3. Adminsistrator or designee will audit doors weekly for 4 weeks and then monthly for 3 months. Administrator or designee will bring the results of the audits to QAPI for reveiw and further recommendations to continue or discontinue.	6/24/22

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	435083	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/17/2022**

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K 363	Continued From page 3 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain protection of corridor openings for one randomly observed corridor door (conference room) as required. Findings include:	K 363		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	435083	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/17/2022**

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K 363	Continued From page 4 1. Observation and testing on 5/17/22 at 11:05 a.m. revealed the corridor door to conference room would not close and latch into the door frame. Interview with the maintenance director at the time of the observation and testing confirmed that finding. He stated he was unaware that door was not properly latching. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		

South Dakota Department of Health

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	10600	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NEIGHBORHOODS AT BROOKVIEW	2421 YORKSHIRE DRIVE BROOKINGS, SD 57006

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/17/22 through 5/19/22. The Neighborhoods at Brookview was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in two randomly observed rooms (janitors closet and therapy bathroom). Findings include: 1. Observation on 5/17/22 at 11:20 a.m. revealed the exhaust ventilation for the janitors closet near the therapy suite was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. 2. Observation on 5/17/22 at 11:23 a.m. revealed the exhaust ventilation for the bathroom in the therapy suite was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding.	S 157	1. All residents that are in therapy area have the potential to be affected. 2. Janitor closet exhaust fan was replaced on 6/8/22. Therapy bathroom exhaust fan was replaced on 6/8/22. These were added to the routine maintenance list to be checked on maintenance rounds. 3. Adminstrator or designee will monitor 2 random exhaust fans weekly for 4 weeks and then 2 exhaust fans monthly for 3 months. The administrator or designee will bring the audit results to QAPI meeting for further review and recommendation to continue or discontinue.	6/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremy Klinkhammer

TITLE: Administrator

(X6) DATE: 6/22/22

FORM CMS-2567(02-99) 6899 MB9211

South Dakota Department of Health

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	10600	A. BUILDING: _____ B. WING _____	05/19/2022

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S 157	Continued From page 1 Interview with the maintenance director at that same time confirmed that finding. He revealed he was also unaware as to why the exhaust ventilation was not working at that location, but believed it was on the same system as the janitors closet in the hall.	S 157		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training program, was conducted from 5/17/22 through 5/19/22. The Neighborhoods at Brookview was found in compliance.	S 000		