STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80607	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL PINES SENIOR LIVING - HURON	1714 OHIO NW HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/6/25 through 10/8/25. Peaceful Pines Senior Living - Huron was found not in compliance with the following requirements: S145, S165, S200, S201, S216, S320, and S450.	S 000		
S 145	44:70:02:12 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 and interview, the provider failed to ensure five of five storage rooms (Memory Care mechanical room, north side Memory Care storage room, storage room by the assisted living nurse's station, two storage rooms by resident room AL122) were equipped with exhaust ventilation. Findings include: 1. Observation on 10/8/25 at 10:45 a.m. revealed the Memory Care mechanical room was over 200 square feet in area and held combustible storage items. The room was not equipped with exhaust air ventilation. Return air ventilation would be acceptable for a storage room with clean storage items. 2. Observation on 10/8/25 at 10:55 a.m. revealed	S 145	Specific to the Memory Care Mechanical room storage, the MC North storage, the AL Nurses' station,and the storage rooms near AL 122, Sentry Electric has been scheduled to add ventilation. This will be completed on November 14, 2025 and will bring these storage areas into immediate correction that is compliant with Administrative Rule 44:70	11/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Metzger | TITLE: Executive Director | (X6) DATE: 11/07/2025

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S 145	Continued From page 1 the Memory Care north side storage room held combustible storage items. The room was not equipped with exhaust air ventilation. Return air ventilation would be acceptable for a storage room with clean storage items. 3. Observation on 10/8/25 at 11:20 a.m. revealed a room by the assisted living nurse's station approximately 88 square feet in area and held combustible storage items. The room was not equipped with exhaust air ventilation. Return air ventilation would be acceptable for a storage room with clean storage items. 4. Observation on 10/8/25 at 10:45 a.m. revealed two rooms adjacent resident room AL122 were approximately 65 feet square feet in area and held combustible storage items. Those rooms were not equipped with exhaust air ventilation. Return air ventilation would be acceptable for a storage room with clean storage items. 5. Interview with administrator A at the time of those observations confirmed those findings.	S 145		
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by:	S 165	Executive Director contacted Sentry Electric . They have been scheduled to add supplemental heat to the Memory Care bathing areas.	11/14/25

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S 165	Continued From page 2 Based on observation and interview, the provider failed to maintain adequate heat for two of two locations in the Memory Care (central shower and central spa) resident bathing areas. Findings include: 1. Observation on 10/8/25 at 11:15 a.m. revealed the central spa and central shower rooms in the Memory Care unit had six-inch forced air supply from the heating and air-conditioning unit. That ventilation was controlled by a thermostat in the Memory Care core area. If the thermostat was not set at a temperature to prompt the unit to deliver heat, the unit would not supply any heat to the room other than that provided by the bathing water temperature. Observations of the public toilet rooms in the assisted living building and assisted living resident shower rooms revealed supplemental heat was provided in those areas with wall-mounted electric cove heaters. The lack of supplemental heat in the Memory Care central spa and central shower showed a lack of equitable personal protection for the most vulnerable residents in the facility. 2. Interview with administrator A at the time of those observations confirmed those conditions.	S 165		
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat	S 200	HME Companies' building and construction team will be onsite visit prior to November 22, 2025 to correct the hinges and to test to ensure the latch is engaged upon closure.	11/22/25

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S 200	Continued From page 3 detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure one of one storage room had a self-closing door (central storage). Findings include: 1. Observation on 10/8/25 at 11:15 a.m. revealed the central storage room corridor door was not self-closing. Two of the three hinges on the door were spring hinges. Testing of the door at the time of the observation revealed the spring hinges were not adjusted tight enough to close the door to latch. 2. Interview with administrator A at the time of the observation and testing confirmed those findings.	S 200		
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 operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not	S 201	Regarding IL EXIT door, a panic bar that integrates with the nurse call system will be ordered by October 31,2025. This panic bar is required equipment that will allow a delayed egress to be established. Once the equipment has been received, this will be installed by PMT and HME Companies Director of Construction or designee. Expecting standard delivery timeline, this item is expected to arrive and be installed prior to the November 22, 2025 deadlinethat has been provided. The ED will maintain communication with the State DOH Representatives throughout this	11/22/25

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S 201	Continued From page 4 met as evidenced by: A. Based on observation, testing, and interview, the provider failed to maintain one of seven exit doors in an operable condition (exit door by independent living and memory care area). Findings include: 1. Observation on 10/8/25 at 3:05 p.m. revealed the exit door by the independent living and memory care area was equipped with a magnetic lock. Testing of the magnetic lock at the time of the observation revealed the lock was not a delayed-egress lock that would comply with LSC Chapter 7.2.1.6.1. There was no access-controlled device in compliance with LSC Chapter 7.2.1.6.2. Those would be the only acceptable options at that location, as assisted living residents had access to that area. 2. Interview with the administrator at the time of the observation and testing revealed independent living residents could egress by the use of a fob. She also confirmed the door would release upon activation of the fire alarm system. B. Based on observation and interview, the provider failed to install an illuminated EXIT sign from the north and south corridors to show a path for a second required EXIT. Findings include: 1. Observation on 10/8/25 at 2:45 p.m. revealed the corridor junction from the lobby to the memory care area was not equipped with an illuminated EXIT sign visible from the north and south corridors to show exiting to the main entrance as a second required exit.	S 201	Specific to the corridor junction from the lobby to Memory Care, Sentry Electric is scheduled to install an illuminated Exit sign that is visible from the north and south corridors.	11/14/25

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S 201	Continued From page 5 2. Interview with administrator A at the time of the observation confirmed that finding. C. Based on observation, record review, and interview, the provider failed to maintain the natural gas generator in operating condition (documentation of weekly checks, monthly load runs, monthly battery conductivity testing, and battery terminal protective covers). Findings include: 1. Observation on 10/8/25 at 3:05 p.m. revealed the natural gas generator was located outside the mechanical room. Record review at 3:15 p.m. revealed there was no documentation that the required weekly visual checks, monthly load runs for 30 minutes under load along with a 5-minute cool down period, or monthly generator battery conductivity testing was completed. 2. Observation on 10/8/25 at 11:30 a.m. revealed there was no remote annunciator for the generator located at a manned location. Interview with administrator A at the time of the observation revealed an electronic tablet had been recently installed in the mechanical room, which was not a manned location. The generator battery terminals were not covered as required. 3. Interview with administrator A at the times of the observations confirmed those findings. She stated no training was provided regarding the use of the generator annunciator tablet. D. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test documentation was not available).	S 201	Sentry was here and education was provided to ED and DON on tablet located in Mechanical room. Education was on how to find the documentation of weekly checks, monthly load runs and monthly battery conductivity. Sentry will install an audible and visual alarm box for the generator at a 24 hr manned nurses station on 11/14/2025. Sentry will provide education on the alarm box and generator tablet to ED, DON, PTM and Med Aids.	10/14/25 11/14/25

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S 201	Continued From page 6 Findings include: 1. Record review on 10/8/25 at 3:15 p.m. revealed no documentation that quarterly flow testing had been performed in 2024 and 2025 as required by NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 2. Interview with administrator A at 3:20 p.m. revealed the provider had a recent turnover in the maintenance department and confirmed those findings.	S 201	ED contacted Building Sprinkler on 10/28/2025 stating need for quarterly flow testing to be done and to be added to a quarterly schedule. Building Sprinkler was here on 10/29/2025 to conduct quarterly flow test and facility has been added to quarterly schedule.	10/29/25
S 216	44:70:03:04 Fire Alarm Systems A manually operated, electrically supervised fire alarm system must be installed in each facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to document the reception of the fire alarm signal to the monitoring agency for fire drills held in 2024 and 2025. Findings include: 1. Record review on 10/8/25 at 3:00 p.m. revealed no documentation that the fire alarm signal used for fire drills in 2024 and 2025 was received by the monitoring agency as required. 2. Interview with administrator A at 3:20 p.m. revealed the provider had a recent turnover in the maintenance department.	S 216	Facility PMT notifies CMS of fire drill, CMS puts the system on standby until the drill is over then the PMT calls CMS back stating the drill is over putting the system back in active status. On 10/29/2025 ED placed call to both Automatic Building Controls and alarm monitoring system CMS regarding alarm signal, both systems state when the PMT calls for the standby and the alarm is pulled at the facility there is not alert that is sent to either of these companies. ED will add documentation to fire drill logs the time CMS was of notified of drill and who notified CMS and the time of when system was returned to active status	10/29/25
S 320	44:70:08 Prevention And Control Of Pneumonia	S 320		

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S 320	Continued From page 7 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 record review, interview, and policy review the provider failed to ensure one of one resident (1) received his pneumonia vaccination. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He admitted to the memory care unit on 2/21/25. *His record indicated he had not received his pneumonia vaccination. *His record indicated he had not signed a refusal to receive a pneumonia vaccination. 2. Interview on 10/7/25 at 12:56 p.m. with director of nursing (DON) B regarding resident 1's pneumonia vaccine revealed: *She confirmed resident 1 had not received his pneumonia vaccine. *She expected a resident's pneumonia vaccine be completed within 14 days of admitting to the facility or that they had signed a refusal to receive the vaccine. 3. Review of the providers 7/15/22 Prevention and Control of Influenza, Pneumonia, & Covid-19 policy revealed: * "The community will arrange for an	S 320	All current residents will have audit of charts for Pneumonia vaccine done by DON. Residents found not in compliance and consenting to vaccine will have vaccine completed either by primary provider or DON at community. All new residents will be presented upon admission with the community Vaccine Consent/Declination form and given the ability to either accept or decline vaccination for Influenza, Pneumococcal, COVID 19 and COVID Boosters. ED DON and Sales Director educated on new vaccine consent form and need for form to be filled out during admission process and given to DON on 10/10/25. Completed vaccine forms to be uploaded to resident's charts for further reference.	11/21/25

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S 320	Continued From page 8 immunization for pneumococcal disease." *"If Immunization is lacking and the resident's physician recommends immunization, the facility shall encourage a resident to obtain immunization for pneumococcal pneumonia within 14 day of admission." *"A pneumococcal vaccination may be waived for the resident because of previous history of vaccination, religious beliefs, medical contraindication, or refusal by the resident." *"Documentation of the vaccination or its waiver shall be recorded in the resident's record."	S 320		
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 food temperatures were checked and documented as completed for 158 of 285 resident meals served from the main kitchen from 7/3/25 through 10/5/25. Findings include: 1. Observation and interview on 10/6/25 at 3:30 p.m. with cook D in the kitchen revealed: *A clipboard with sheets of paper labeled Food Temperature Log. *She stated that was where the food temperatures were documented.	S 450	The Director of Dining Services provided education to all dietary employees in an inservce on proper and safe food temperatures, new temperature log, and new audit tool. Staff also educated that if an audit of found out of compliance that is will result in disciplinary action. The Director of Dining Services will audit food temp logs while on shift for four weeks then two times a week for four weeks, then random audits to assure compliance. Starting November 3, 2025. All audits will be brought to quarterly QUAPI meetings and reviewed.	10/24/25

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S 450	Continued From page 9 *She confirmed food temperatures were to be documented for every meal served. *She agreed there was no documentation for food temperatures on 10/4/25 and 10/5/25. *She put her initials by the food temperatures she checked and documented so her supervisor knew when she worked. 2. Interview on 10/6/25 at 4:10 p.m. with director of culinary services C revealed: *She was aware some dietary staff were not documenting food temperatures appropriately. *She expected the dietary staff to check the temperature of the foods before every resident meal and to document those temperatures. 3. Review of the provider's Food Temperature Logs from 7/3/25 through 10/5/25 revealed there were no documented food temperatures for 158 of the 285 resident meals served during that time frame. 4. Interview on 10/8/25 at 8:50 a.m. with administrator A revealed: *She knew there had been an issue with food temperature documentation. *She thought the dietary staff was doing a better job of documenting food temperatures. *She expected dietary staff to follow the provider's policy for food temperature documentation. *She agreed food temperature documentation was not being completed for all resident meals. 5. Review of the provider's updated 8/1/22 Food Temperature policy revealed: *"The Facility will ensure food temperatures will be taken and recorded before each meal service. Food will be cooked or cooled to ensure proper serving temperature before each meal service."	S 450		

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S 450	Continued From page 10 *"Before meals, the head chef or designee will take the temperatures of all menu items and record on the Food Temperature Log."	S 450		