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	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhoods at Brookview	2421 Yorkshire Dr Brookings, SD 57006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, observations, document review, and policy review, the provider failed to assess three of five sampled residents (1, 4, and 5), all of whom had either experienced a fall related to a recliner or lacked access to their recliner controls. The provider also failed to update residents' care plans and educate staff as indicated in the incident reports.Findings include:1. Review of Resident 1's EMR revealed he was admitted to the facility on [DATE]. He had diagnoses of osteoarthritis (a condition where the cartilage in joints is worn down causing pain and stiffness), Alzheimer's (a progressive brain disorder causing memory loss), mild cognitive impairment (mild confusion), hypertension (high blood pressure), depression, right hip pain, low back pain, glaucoma (high pressure inside the eye causing vision changes), atrial fibrillation (irregular heart beat), and congestive heart failure (where the heart cannot pump enough oxygenated blood to meet the body's needs, causing blood and fluid to back up in organs like the lungs, abdomen, and legs.He was hospitalized on [DATE] for confusion/disorientation, pale/dusky (pale blueish color of the skin), coarse lung sounds (rattling sound), and shortness of breath with ambulation. He returned from the hospital on [DATE] and started receiving hospice care (end-of-life care focusing on comfort).He had fall risk assessments completed on 5/20/25, 5/26/25, 8/17/25, 10/17/25, and 10/22/25 that indicated he had a high risk of falling. He fell on 9/28/25 when he lost his balance in the bathroom and did not receive a major injury. On 10/4/25, he fell near his bed and did not receive an injury. On 10/17/25, he was more confused, thinking he saw marbles on the floor and claimed to slip on them. He was found on the floor in his room and did not have an injury. On 10/22/25, he was found sitting on the floor in his room between his bed and recliner. The recliner's footrest had been elevated, and staff reported he had been sitting in his recliner prior to being found on the floor. RN, NS J assessed him, and he complained of pain in his pelvis and hips with movement and when he was touched. His right leg had been slightly longer than his left, his right leg was turned outward, and he had pain with the movement of his right hip (indicating he had a possible hip fracture). His family was updated on his fall and status, and they declined further evaluation at the emergency room for him. They wanted him to remain at the facility and to be kept comfortable. His 6/20/25 (most current in the EMR) care plan indicated he was independent with bed mobility, independent with transferring (moving from one place to another), and walking with a walker, he did not use a wheelchair, and he was independent with his dressing, eating, toilet use, and personal hygiene. On 9/18/25, it was added to his care plan that he was a high fall risk. His fall interventions, last updated on 10/22/25, were: Encourage to call for assistance with toilet hygiene., Encourage to use anti slip footwear., Reinforce safety., Remind to use of footwear during ambulation., Encourage to sit while getting his pants over his feet and lower legs, once that is done then stand for pulling them up., double call light in place, fall mat beside bed, and bed at low position.His 10/17/25 paper care plan indicated he needed the assistance of one to two staff, a gait belt, and a walker to transfer. He needed one staff member to assist him with ambulation with his walker or wheelchair, and his mental status was alert, confused, and forgetful.His 10/21/25 Hospice care plan indicated he needed the assistance of two staff members to reposition and did not include how he transferred or ambulated.His Brief Interview for Mental Status (BIMS) score was 8, per the facility-reported incident report completed on 10/23/25, which indicated he had moderate cognitive impairment.He passed away at the facility on 10/23/25 at 10:46 a.m. on hospice services.2. Review of resident 4's EMR revealed she had a fall on 8/9/25 at 3:45 a.m., where she reported she had a dream and rolled out of her bed. Her fall interventions included: To ensure her bed was in a low position, remind her to use her call light, and not to get up on her own. Staff were to complete frequent, extensive rounding and to offer her assistance to the bathroom. Her care plan did not indicate safety measures related to the use of her electric recliner. She had a lift chair/recliner assessment completed on 11/12/25, where she was considered safe to use her recliner, and her BIMS score was 4, which indicated she had severe cognitive impairment.3. Review of Resident 5's EMR revealed he had diagnoses of Parkinson's (a progressive neurodegenerative disorder that affects movement, causing tremors, stiffness, slowed movement, and balance), atrial fibrillation, hypertension, anxiety, and depression.His 9/15/25 BIMS score was 14, which indicated he was cognitively intact.He had a fall on 9/24/25 at 4:00 p.m., where he was found lying by the end of his recliner, and the recliner was in a slightly elevated position. Per the fall report, he was reaching forward to stand up and move to his wheelchair independently, but his arms were weak, and he fell. He had nonslip black strips in front of his recliner. He did not receive an injury, and the following