STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW HEALTHCARE CENTER	401 SOUTH FIRST AVENUE PO BOX 68, WOONSOCKET, South Dakota, 57385

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/21/25 through 7/24/25. Prairie View Healthcare Center was found not in compliance with the following requirements: F695 and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/21/25 through 7/24/25. Areas surveyed included resident abuse, quality of care, and elopement. Prairie View Healthcare Center was found not in compliance with the following requirements: F551, F609, and F689.	F0000		
F0551 SS = D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.	F0551	Prairie View Healthcare Center will ensure that resident representatives of residents with cognitive impairment are notified of any changes to their status and of any elopements or presumed elopements. Residents identified to be affected by the deficient practice. Resident 24 was affected by a change in status and a presumed elopement that were not notified to their representatives. How corrective action will be accomplished for those residents found to have been affected by the deficient practice Contact information for the secondary representative of resident 24 was added to the resident's chart on 7/5/25 to ensure that current representatives can be contacted.	8/15/2025

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 reverse for further 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
Kayla Evans	Administrator	8/20/2025

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F0551 SS = D	Continued from page 1 §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure the resident representative had been notified of an elopement and change in the resident's status for one of one sampled resident (24) with cognitive impairment. The resident was identified as at risk for elopement and had eloped (left the facility grounds without staff knowledge) on 7/4/25. Findings include:	F0551	(Continued from page 1) How the facility will identify other residents having the potential to be affected by the same deficient practice Current residents with cognitive impairment who have a representative have the potential to be affected. Current residents with cognitive impairment who are at risk for an elopement and have a representative have the potential to be affected. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing reviewed the most recent BIMS assessment report on current residents to identify those with cognitive impairment and then confirmed contact information for their representatives on 7/25/2025 to ensure that resident representatives can be contacted to exercise their rights. The Resident Sign In/Sign Out Log was updated to include the name of the person signing the residents in and out of the building to ensure that essential details are notified to the resident representatives during an elopement or presumed elopement. A second Resident Sign In/Sign Out binder was added to the north entrance/exit to ensure that residents are signing in and out of the facility. The current licensed nurses were educated on standard events that must be notified to a representative of cognitively impaired residents.	

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F0551 SS = D	Continued from page 2 1. Review of the provider's 7/24/25 SD DOH FRI regarding resident 24 revealed: *On 7/4/25 at 6:57 p.m., resident 24 "was found to be at the apartment building across the street." *"She [resident 24] had signed out of the facility earlier in the day, therefore the incident was not reported." *The resident had a 5/5/25 contract agreement "that the resident would not leave the premises of the facility." -This contract had been signed by resident 24 and social services director (SSD) C. It had not been signed by resident 24's resident representative. *The resident had left the facility without staff awareness on 7/4/25, and that event had not been reported to resident 24's representative or SD DOH until 7/24/25. 2. Review of the facilities' sign-out log revealed on 7/4/25, resident 24 signed out at "Noon" and returned at 1:00 p.m. That was the only time resident 24 signed out that day. 3. Review of resident 24's "Guidelines for Outside Activity" contract agreement with the facility revealed: *"Resident MUST sign herself out and in each time she leaves the building." *"Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside. *"Resident will remain on facility property when [she] goes outside: will not go up town to any place of business or location w/o [without] family or facility personnel." *"Resident [24] will not go to the apartments to the East or North of the facility. *The contract was signed on 5/5/25 by resident 24 and SSD C. 4. Review of resident 24's electronic medical record revealed:	F0551	(Continued from page 2) How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit BIMS assessment report on current residents to identify those with cognitive impairment and then confirm contact information for their representatives. This audit will be conducted weekly for one month, then twice a month for one month, then once a month for a month. This audit will ensure that resident representatives can be contacted to exercise their rights. The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI) meetings. The Director of Nursing or designee will audit the charts of residents who are cognitively impaired and have a representative, for indication of status changes that need to be notified to their representatives. This audit will be conducted weekly for one month, then twice a month for one month, then once a month for a month. This audit will ensure that resident representatives can be contacted to exercise their rights. The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI) meetings. The Director of Nursing or designee will conduct one elopement drill a month for three months. The findings will be reviewed at the montly Quality Assurance/Performance Improvement (QAPI) meetings. The Administrator is responsible for implementing the acceptable plan of correction.	

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F0551 SS = D	Continued from page 3 *She was admitted on 2/12/25. *Her diagnoses included anxiety, nicotine dependence, and dementia (a group of symptoms affecting memory, thinking, and social abilities). *Her 4/19/25 Elopement Risk Evaluation indicated that she was an elopement risk; her wandering placed her at "significant risk of getting [in] to an unsafe situation, had a history of leaving the center without notifying staff members, and on 4/19/25 she "left [a] supervised area to walk around outsid[e]." *Her 5/19/25 Brief Interview of Mental Status (BIMS) assessment score was 10, which indicated she was moderately cognitively impaired. *A 2/14/25 Durable Power of Attorney (POA) for Health Care was signed by resident 24, designating her daughter and son as her POAs. -Her POAs had been involved in assisting the resident with making decisions and with signing documents since that time. *Resident 24's POAs were listed as her emergency contact persons. 5. Interview on 7/24/25 at 9:25 a.m. and again at 4:38 p.m. with resident 24's son revealed: *His mother was admitted to the facility after a hospitalization and illness several months ago because she required more assistance and supervision than he or his sister could provide to her at home. *He had been notified in April 2025 when his mother had walked away from an outside group activity at the facility, but he had not been notified when she left the facility on 7/4/25. *On 7/5/25, while at the facility, he was informed that the "board" had decided that his mother could "come and go" from the facility, including on overnight visits, if she signed herself out, that the facility did not need to notify him or his sister when she left the facility, and that the facility was not responsible if something happened after she signed herself out of the facility. *He was unsure who the "board" members were who had made those decisions.	F0551		

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F0551 SS = D	Continued from page 4 *SSD C made a phone call to her supervisor while he was present in the facility on 7/5/25, to confirm the above information he was told, because he was questioning the decision to "change her status at that moment," and he continued to be worried for her safety. 6. Interviews on 7/24/25 between 9:45 a.m. and 10:45 a.m. with staff members S and T, who requested anonymity, revealed: *On 7/4/25, around 7:00 p.m., staff members identified they had not seen resident 24 for some time that day and began looking for her. *Resident 24 was allowed to sign herself out to go outside and smoke, but she was not allowed to leave the facility property. *Resident 24 had not signed out that evening and was not found within the facility or outside the facility in the designated smoking area. *Staff were worried about resident 24's safety because she had not indicated that she was leaving, and it was raining that day. *Resident 24 was found at the apartments next door. Staff encouraged her to return to the facility; however, resident 24 refused to return to the facility. *Resident 24 then went to the shed, behind the facility, and took out her "trike" [a three-wheeled bicycle] and "took off down the street," which was when staff members reported they lost sight of resident 24. *Resident 24 was then seen by one of those staff members about a block away from the facility on that trike. *Charge nurse U had called the supervisors on call that evening while staff members searched for resident 24 and tried to convince the resident to return to the facility. *Staff members S and T were told, "Just let her go," not to report the incident, not to document the incident, and not to mention or talk about the incident again by charge nurse U. *Resident 24's son and daughter were her POAs and had not been notified of the resident's elopement. *Resident 24's son had been angry about the incident	F0551		

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F0551 SS = D	Continued from page 5 that had occurred on 7/4/25 and he came to the facility on 7/5/25 to talk to the facility staff about his concerns of his mother's safety. 7. Interview on 7/24/25 at 2:00 p.m. and again at 2:50 p.m. with director of nursing (DON) B, administrator A, and SSD C revealed: *DON B confirmed that resident 24's son and daughter had not been notified of the 7/4/25 "incident" because it had not been considered an elopement. *Administrator A stated that after reviewing additional documentation, it was determined that the "incident" on 7/4/25 should have been considered an elopement. *Administrator A expected that resident 24's POA or resident representative would be notified of all elopements or changes in her status. 8. A resident representative rights and notification policy was requested from DON B on 7/24/25 at 12:10 p.m. with referral to the Facility Admission Agreement. 9. Review of the provider's June 2020 Facility Admission Agreement packet revealed: *A November 2016 Notice of Resident Rights Under Federal Law document indicated: -"The resident has the right to formulate an Advance Directive." -" The resident has the right to be informed, in advance, of the care furnished…" -"The resident has the right to be informed of, and participate in his/her treatment, including: The right to be fully informed…participate in the planning process…to be informed I advance of any changes in the plan of care." *The provider's December 2023 Resident Handbook indicated: -"The center will abide by any instructions provided in your Advance directive…Health Care Power of Attorney…" *There was no information specific regarding notification to a resident's representative of a change in status or of an elopement.	F0551		

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F0551 ~~F0609~~ SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, record review, and policy review, the provider failed to report an elopement in the required timeframe to the SD DOH for one of one sampled resident (24) with cognitive impairment and identified at risk for elopement, who had eloped (left the facility grounds without staff knowledge). Findings include: 1. Review of the provider's 7/24/25 SD DOH FRI regarding resident 24 revealed: *On 7/4/25 at 6:57 p.m., resident 24 "was found to be at the apartment building across the street." *"She [resident 24] had signed out of the facility	F0551 F0609	Prairie View Healthcare Center will ensure to report elopements in the required time frame to the SD DOH. Residents identified to be affected by the deficient practice Resident 24 with cognitive impairment was identified to be at risk for elopement and left the facility grounds without staff knowledge. How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident 24 returned to the facility the same day and was reminded by current staff to sign in and out when leaving and returning to the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice Current residents identified to be at risk for elopement have the potential to be affected. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing or designee educated the current licensed nurses on reportable events. How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will assign an assessment on reportable events to current licensed nurses once a month for three months.	8/15/2025

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F0609 SS = D	Continued from page 7 earlier in the day, therefore the incident was not reported." *The resident had a 5/5/25 contract agreement "that the resident would not leave the premises of the facility." *The resident had left the facility without staff awareness on 7/4/25, and that event had not been reported to resident 24's representative or SD DOH until 7/24/25. -That was 20 days later. 2. Review of the facilities' sign-out log revealed on 7/4/25, resident 24 signed out at "Noon" and returned at 1:00 p.m. That was the only time resident 24 signed out that day. 3. Review of resident 24's "Guidelines for Outside Activity" contract agreement with the facility revealed: *"Resident MUST sign herself out and in each time she leaves the building." *"Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside." *"Resident will remain on facility property when [she] goes outside: will not go up town to any place of business or location w/o [without] family or facility personnel." *"Resident [24] will not go to the apartments to the East or North of the facility." *The contract was signed on 5/5/25 by resident 24 and social services director D. 4. Interviews on 7/24/25 between 9:45 a.m. and 10:45 a.m. with staff members S and T, who requested anonymity, revealed: *On 7/4/25, around 7:00 p.m., staff members identified that they had not seen resident 24 for some time and began looking for her. *Resident 24 was allowed to sign herself out to go outside and smoke, but she was not allowed to leave the facility property.	F0609	(Continued from page 7) The findings will be reviewed at the monthly Quality Assurance/Performance Improvement (QAPI) meetings. The Administrator is responsible for implementing the acceptable plan of correction.	

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F0609 SS = D	Continued from page 8 *Resident 24 had not signed out that evening on 7/4/25 and was not found within the facility or outside in the designated smoking area. *Staff were worried about resident 24's safety because she had not indicated that she was leaving, and it was raining that day. *Resident 24 was found at the apartments next door. Staff encouraged her to return to the facility; however, resident 24 refused to return to the facility. *Resident 24 then went to the shed and took out her "trike" [a three-wheeled bicycle] and "took off down the street," which was when staff members reported they lost sight of resident 24. *Resident 24 was then seen by a staff member about a block away from the facility on that trike. *Registered nurse (RN) U had called the supervisors on call that evening while staff members searched for resident 24 and tried to convince resident 24 to return to the facility. *Staff members S and T were told by LPN U that she had been instructed by the supervisors to "just let her go," not to report the incident, not to document the incident, and not to mention or talk about the incident again. 5. Interview on 7/24/25 at 2:00 p.m. and again at 2:50 p.m. with director of nursing (DON) B, administrator A, and social services director (SSD) C revealed: *DON B stated that there was no investigation into resident 24's 7/4/25 "incident" because it had not been considered an elopement at that time. *Administrator A stated that after reviewing additional documentation, it was determined that the "incident" on 7/4/25 should have been considered an elopement. *Administrator A expected that all elopements would be reported to the state agency immediately and investigated. She expected the results of any investigation related to a resident's elopement to have been documented and reported to the state agency within five working days. *DON B and Administrator A confirmed that there was no documentation of resident 24's 7/4/25 elopement in her electronic medical record, and there was no	F0609		

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F0609 SS = D	Continued from page 9 investigation documentation from that 7/4/25 elopement. 6. Review of resident 24's electronic medical record revealed: *She was admitted on 2/12/25. *Her diagnoses included anxiety, nicotine dependence, and dementia (a group of symptoms affecting memory, thinking, and social abilities). *Her 4/19/25 Elopement Risk Evaluation indicated that she was an elopement risk; her wandering placed her at "significant risk of getting [in] to an unsafe situation, had a history of leaving the center without notifying staff members, and on 4/19/25 she "left [a] supervised area to walk around outsid[e]." *Her 5/19/25 Brief Interview of Mental Status (BIMS) assessment score was 10, which indicated she was moderately cognitively impaired. 7. Attempts made to contact RN U by phone were unsuccessful, and she was not available for an interview during the survey. 8. Review of the provider's February 2025 Elopement/Wandering policy revealed: *"The resident/patient exits the Center without staff knowledge OR the resident/Patient enters an unsafe area without staff knowledge or presence." *"A resident is found in the parking lot of the Center by a staff [member] or visitor without staff knowledge or presence. This is elopement." *"A resident exits the front door without staff knowledge or presence. This is elopement." *"If [the] resident exhibits exit seeking behavior, the episodes are documented in the resident medical record. Documentation includes interventions used and their effectiveness." Review of the provider's September 2017 Abuse Reporting and Response policy revealed: *"The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of	F0609		

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F0609 SS = D	Continued from page 10 residents…in accordance with state and federal laws." *"Staff immediately reports all alleged or suspected violations to the supervisor and Executive Director." *"The Executive Director or designee reports alleged violations to the state's survey agency and other officials in accordance with state law…" *"The Center reports the results of all investigations to the Executive Director and to other officials in accordance with State law, including to the State Survey Agency within 5 working days of the incident." *It had been "Updated October 202." It was unknown what year, as the last digit of the date was not present.	F0609		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to: *Provide adequate supervision for one of one sampled resident (24) during an outside activity by one of one activities assistant L. *Ensure the safety of one of one sampled resident (24) with cognitive impairment, identified at risk for elopement, who had eloped (left the facility grounds without staff knowledge) on 7/4/25. Findings include: 1. Review of the 4/19/25 SD DOH FRI regarding resident 24 revealed: *On 4/19/25 at 5:32 p.m. the report had been submitted	F0689	Prairie View Healthcare Center will ensure to provide adequate supervision during outside activities and ensure safety for residents with cognitive impairment at risk for elopement. Residents identified to be affected by the deficient practice Resident 24 with cognitive impairment was identified to be affected by inadequate supervision during outside activities and at risk for elopement. How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident 24 was checked on by the current staff when returned to the facility grounds. How the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing reviewed the most recent BIMS assessment report on current residents to identify those with cognitive impairment. Residents who indicate cognitive	8/15/2025

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F0689 SS = D	Continued from page 11 that indicated resident 24 had eloped from the facility at 2:50 p.m. on 4/19/25. *The resident had told activities assistant L she wanted to see the kids at the easter egg hunt on the other side of the facility. *Resident 24 had walked around to the other side of the facility and was out of staff's sight. *The resident was found by activities director (AD) V walking around the back side of the facility towards an entrance to the facility. *The resident refused to be assessed or to have her vitals (blood pressure, temperature, pulse, respirations, and oxygen level) taken after returning to the facility. -The resident was assessed an hour later by nursing staff and her vitals were stable. *The on-call physician, family, and the local sheriff were notified of the resident's elopement. *Resident 24's care plan indicated she needed to be accompanied by family, a responsible party, or a staff member when leaving the facility. 2. Review of resident 24's electronic medical record (EMR) revealed she: *She was admitted on 2/12/25. *Her diagnoses included anxiety, nicotine dependence, depression, sepsis (serious condition in which the body responds improperly to an infection), dementia (decline in mental ability that interferes with daily life), and behavioral disturbance (disruptive behaviors). -A Brief Interview for Mental Status assessment (BIMS) completed on 2/12/25 with a score of 10, indicated she was moderately cognitively impaired. *On 2/12/25 she had been assessed and was determined not at risk for elopement. *On admission she had a smoking safety evaluation, and determined she could smoke independently. *She was instructed to only smoke outside in the designated area.	F0689	(Continued from page 11) impairment who participate in activities outside were communicated to current staff to ensure supervision is assigned. The Director of Nursing reviewed the current residents who might be at risk of elopement. Residents who indicate elopement risk and participate in outdoor activities have been communicated to current staff to ensure appropriate supervision is assigned. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur Current staff were educated in supervising current residents who indicate cognitive impairment during outside activities. Current staff were educated in supervising current residents who are at risk for elopement during outside activities. How the facility plans to monitor its performance to make sure that solutions are sustained The administrator or designee will randomly attend scheduled outdoor activities to observe for adequate resident supervision. This observation audit will occur once a week for one month, then once a month for one month. The audit findings will be reviewed at the monthly Quality Assurance/Performance Improvement (QAPI) meetings. (Continued on page 13)	

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F0689 SS = D	Continued from page 12 - When she would go outside to smoke, she was to sign in a book with her name, date, time of leaving and time of returning. *Prior to 4/19/25, she did not have a history of wandering, exit-seeking, or elopement. 3. Interview on 7/22/25 at 10:00 a.m. with resident 24 revealed: *She reported on 4/19/25 she had walked around to the other side of the building during an outside activity. *She had indicated, she told activities assistant L that she was going to walk around the building. *At that time, she was allowed to be outside with staff supervision. *After she had returned to the facility, she had indicated to staff that she went for a "walkabout" when she had walked around the building. 4. Interview on 7/22/25 at 10:12 a.m. with director of nursing (DON) B, regarding resident 24's 4/19/25 elopement revealed: *The resident had walked around the facility on 4/19/25 at 2:50 p.m. and she was out of sight of staff for only a short amount of time, about 45 seconds. *The resident had returned on her own to the facility without harm. * On 4/19/25 resident 24's care plan had been updated to reflect she was an elopement risk. *Resident 24's care plan indicated all exit seeking behaviors must be documented in resident 24's EMR. *The resident's care plan indicates an elopement risk will be completed quarterly on her and this was initiated on 4/19/25. 5. Interview on 7/24/25 at 9:30 a.m. with certified medication aide (CMA) Q revealed: *She referred to a pocket care plan staff used to care for the residents. Those included resident cares and information about them.	F0689	(Continued from page 12) The Administrator or designee will audit the sign-in and sign-out logs for current residents who are at risk for elopement. Interviews will be conducted with one resident from that log and one current staff member who worked at the time the resident signed out, to determine whether the resident had appropriate supervision during their outdoor activities. Audits will occur weekly for one month, then twice a month for another month, and then once a month for one final month. The findings will be reviewed at the monthly Quality Assurance/Performance Improvement (QAPI) meetings. The Administrator is responsible for implementing the acceptable plan of correction.	

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F0689 SS = D	Continued from page 13 *She had indicated resident 24 was only to be outside with supervision of staff or a responsible person. *She had indicated that on 4/19/25 resident 24 had a BIMS score of 10 and needed staff supervision. 6. Interview on 7/24/25 at 12:24 p.m. with activities director (AD) V revealed: *On 4/19/25 at 2:50 p.m. resident 24 was outside being supervised by activities assistant L. *That day the resident had walked around to the other side of the facility and was out of sight of the staff for only a couple minutes . *A code white (missing resident) was called to inform all staff of a missing resident for them to start looking for her. *Staff then found the resident had been seen by staff walking up the sidewalk next to the building and had come from the opposite side of the facility. 7. Review of the provider's 7/24/25 SD DOH FRI regarding resident 24 revealed: *On 7/4/25 at 6:57 p.m., resident 24 "was found to be at the apartment building across the street." *"She [resident 24] had signed out of the facility earlier in the day, therefore the incident was not reported." *The resident had a 5/5/25 contract agreement "that the resident would not leave the premises of the facility." *The resident had left the facility without staff awareness on 7/4/25, and that event had not been reported to resident 24's representative or SD DOH until 7/24/25. 8. Review of the facilities' sign-out log revealed on 7/4/25, resident 24 signed out at "Noon" and returned at 1:00 p.m. That was the only time resident 24 signed out that day. 9. Additional review of resident 24's electronic medical record revealed: *Her 4/19/25 Elopement Risk Evaluation indicated that	F0689		

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F0689 SS = D	Continued from page 14 she was an elopement risk; her wandering placed her at "significant risk of getting [in] to an unsafe situation, had a history of leaving the center without notifying staff members, and on 4/19/25 she "left [a] supervised area to walk around outsid[e]." *Her 5/19/25 BIMS assessment score was 10, which indicated she was moderately cognitively impaired. *There was no documentation of resident 24's elopement on 7/4/25 as indicated in the 7/24/25 SD DOH FRI. *There was no documentation of the resident's exit-seeking or other behaviors or incidents on 7/4/25. *A 7/5/25 BIMS assessment score of 13, which indicated she was cognitively intact. -That BIMS assessment was completed the day after resident 24 left the facility without staff knowledge on 7/4/25. *A 7/20/25 Elopement Risk Evaluation indicated a score of "NA [not applicable]": -Her cognition was impaired with poor decision-making skills. -She had a history of wandering. -She had a diagnosis of dementia/cognitive impairment. -She had a history of leaving the facility without notifying staff. -She had a substance use disorder. -She had "no reported episodes of wandering in the past 3 months." -Risks included: "Hospitalization, Fall/Injury/Bone Fracture, Being reported as a missing person/elopement." -The resident had been educated on signing out and telling a staff member that she was leaving before she left, and the risks associated with leaving the facility.She acknowledged the risks and understood the process of leaving the facility. -She was determined not to be an elopement risk and "allowed to leave facility is signed out/policy [It was unclear what this indicated]."	F0689		

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F0689 SS = D	Continued from page 15 10. Review of resident 24's "5/5/25 Guidelines for Outside Activity" contract agreement with the facility revealed: *"Resident MUST sign herself out and in each time she leaves the building." *"Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside." *"Resident will remain on facility property when [she] goes outside: will not go up town to any place of business or location w/o [without] family or facility personnel." *"Resident [24] will not go to the apartments to the East or North of the facility." *The contract was signed on 5/5/25 by resident 24 and social services director C. 11. Review of resident 24's care plan revealed: *A 5/28/25 problem area indicated "[Resident 24] is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t [related to] Cognitive deficits, Depression, Mood/Behaviors, [and] Physical Limitations." *A 6/16/25 problem area indicated "[Resident 24] has an alteration in safety r/t: cognitive impairment and being a risk for elopement off the [facility name] Campus." That was deleted and revised on 7/5/25 to indicate "Resident [24] is her own responsible party." *A 6/16/25 goal for the above problem area was to "Prevent [resident 24] from risk, including exposure to dangerous environmental factors, increased risk of falls or accidents, and potential for exploitation or abuse." *A 6/6/25 intervention indicated "[Resident 24] will be accompanied by family, responsible party, or center staff member when leaving the center. Or approved outings by daughter POA [Power of Attorney]." That was deleted and revised on 7/5/25 to indicate "[Resident 24 will be compliant with facility sign [sign] out/sign in process. These are approved outings by [her] daughter POA."	F0689		

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F0689 SS = D	Continued from page 16 *A 6/16/25 intervention indicated "If [resident 24] exhibits behavior leaving campus, the episodes are documented in [resident 24's] medical record. Documentation includes interventions used and their effectiveness." That was deleted and revised on 7/5/25 to indicate "If [resident 24] exhibits behaviors of not signing B/4 [before] leaving then [the] facility & [and] signing in after returning, the episodes are documented in [resident 24's] medical record. Documentation includes interventions used and their effectiveness." *Resident 24's care plan had been revised on 7/5/25 the day after she left the facility without staff knowledge. 12. Review of resident 24's "7/6/25 Guidelines for Outside Activity" contract agreement with the facility revealed: *"Resident MUST sign herself out and in each time she leaves the building." *"Inform Charge Nurse on duty of her going outside & [and] how long she plans to be outside." *"Resident will notify staff on duty, sign out & [and] back in when [she] goes uptown to any place of business or location on her three wheeled bicycle." *The contract was signed on 7/5/25 by resident 24 and social services director C. *The contract was signed two days after resident 24 had left the facility without staff knowledge on 7/4/25. 13. Interviews on 7/24/25 between 9:45 a.m. and 10:45 a.m. with staff members S and T, who requested anonymity, revealed: *On Friday, 7/4/25, around 7:00 p.m., staff members identified they had not seen resident 24 for some time that day and began looking for her. *Resident 24 was allowed to sign herself out to go outside and smoke, but she was not allowed to leave the facility property.	F0689		

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F0689 SS = D	Continued from page 17 *Resident 24 had not signed out that evening and was not found within the facility or outside in the designated smoking area. *Staff were worried about resident 24's safety because she had not indicated that she was leaving, and it was raining that day. *Resident 24 was found at the apartments next door to the facility. Staff encouraged her to return to the facility; however, resident 24 refused to return to the facility. *Resident 24 then went to the shed behind the facility and took out her "trike" [a three-wheeled bicycle] and "took off down the street," which was when staff members reported they lost sight of resident 24. *Resident 24 was then seen by one of those staff members about a block away from the facility on that trike. *The charge nurse had called the supervisors on call that evening while they searched for resident 24 and tried to convince the resident to return to the facility. *Staff members S and T were told by the charge nurse, "Just let her go," not to report the incident, not to document the incident, and not to mention or talk about the incident again. *Staff members S and T knew resident 24 was allowed to "sign out" to smoke independently in the designated smoking area, but she was not to leave the facility property that day unsupervised because it was part of a posted outside activity agreement for resident 24, and the resident had not been care planned to leave the facility independently. 14. Interview on 7/24/25 at 9:25 a.m. and again at 4:38 p.m. with resident 24's son revealed: *His mother was admitted to the facility after a hospitalization and illness several months ago because she required more assistance and supervision than he or his sister could provide for her at home. *He had been notified in April 2025 when his mother had walked away from an outside group activity at the facility, but he had not been notified when she left	F0689		

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F0689 SS = D	Continued from page 18 the facility on 7/4/25. *On 7/5/25, while at the facility, he was informed that the "board" had decided that his mother could "come and go" from the facility, including on overnight visits, if she signed herself out, that the facility did not need to notify him or his sister when she left the facility, and that the facility was not responsible if something happened after she signed herself out of the *He was unsure who the "board" members were who had made those decisions. *Social services director (SSD) C made a phone call to her supervisor while he was present at the facility on 7/5/25, to confirm the above information he was told, because he was questioning the decision to "change her status at that moment," and he continued to be worried for her safety. 15. Interview and review of resident 24's occupational therapy records on 7/24/25 at 3:58 p.m. with director of rehabilitation R regarding resident 24's participation in therapy revealed: *Resident 24 received occupational therapy services from 6/5/25 through 7/23/25. *Her occupational therapy evaluation included assessing her safety with the use of an adult tricycle on facility grounds and in the community. *On 7/23/25, resident 24 was discharged from occupational therapy with the recommendation "not realistic for off campus due to safety concerns of use with traffic. Can use on campus." *The occupational therapy assistant who completed the safety assessment was on leave and unavailable for interview. 16. Interview on 7/24/25 at 2:00 p.m. and again at 2:50 p.m. with director of nursing (DON) B, administrator A, and social services director (SSD) C revealed: *DON B stated there was no documentation or investigation of resident 24's 7/4/25 "incident" because it had not been considered an elopement. *Administrator A stated after reviewing additional documentation, it was determined that the "incident" on 7/4/25 should have been considered an elopement as the resident had left the facility without the staff's	F0689		

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F0689 SS = D	Continued from page 19 knowledge or supervision. *Administrator A had not been aware of the "Guidelines for Outside Activity" contracts that had been made with resident 24 on 5/5/25 before the incident on 7/4/25 and again on 7/6/25 after the incident occurred on 7/4/25. *Administrator A was surprised that resident 24 had a BIMS assessment score of 10 before the incident on 7/4/25 and had been reassessed to have a BIMS of 13 "magically" on 7/5/25. *SSD C confirmed she had completed resident 24's 7/5/25 BIMS assessment, had updated the outside activity contract, and updated resident 24's care plan to reflect the new agreement. *SSD C stated that resident 24's family had not been involved in the development of the contract but had agreed with it on 7/5/25. -Those documents had been updated after the incident on 7/4/25. *Administrator A expected that all elopements would be reported to the state agency and investigated for potential abuse, neglect, or additional interventions. She expected the results of any investigation related to a resident's elopement to have been documented and reported to the state agency. *DON B and Administrator A confirmed there was no documentation of resident 24's 7/4/25 elopement in her electronic medical record, and there was no investigation documentation from that 7/4/25 elopement. *DON B was unaware of occupational therapy's 7/23/25 discharge recommendation that resident 24 was assessed as unsafe for off-campus use of her trike due to safety concerns. 17. Review of the provider's February 2025 Elopement/Wandering policy revealed: *"The Center evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process." *"The resident/patient exits the Center without staff knowledge OR the resident/Patient enters an unsafe area without staff knowledge or presence." *"A resident is found in the parking lot of the Center	F0689		

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F0689 SS = D	Continued from page 20 by a staff [member] or visitor without staff knowledge or presence. This is elopement." *"A resident exits the front door without staff knowledge or presence. This is elopement." "Residents deemed at risk to elope…are accompanied by family, responsible party, or a center staff member when leaving the center for appointments… are ai eyesight when on center sponsored outings. If staff are unable to keep the resident in line of sight, the resident is accompanied by a staff member assuring resident safety." *" Recurrent evaluations are completed quarterly for those at risk to elope… with [a] change in condition and following elopement events. The care plan is reviewed and updated as appropriate." *"If [a] resident exhibits exit seeking behavior, the episodes are documented in the resident's medical record. Documentation includes interventions used and their effectiveness." Review of the provider's June 2020 Facility Admission Agreement packet revealed: "Your stay begins with a complete assessment of cognitive and physical health so that your care team may provide you with comprehensive attention specific to the care you need." *"Care plans are individualized for every patient based on their diagnosis and needs. The goal is to maximize each patient's functional abilities…your needs and the risks associated with them change over time, and we review your plan of care regularly to make sure it continues to meet your needs."	F0689		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F0695	Prairie View Healthcare Center will ensure to follow proper infection control practices for the cleaning and storage of oxygen equipment required for the use of Continuous Positive Airway Pressure (CPAP) machine.	8/15/2025

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F0695 SS = E	Continued from page 21 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure proper infection control practices had been followed for the cleaning and storage of oxygen equipment for two of two sampled residents (21 and 22) who required the use of a Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open). Findings Include: 1. Observation and interview on 7/22/25 at 9:59 a.m. with residents 21 and 22 in their shared room revealed: *There were two CPAP machines on the nightstand between the residents' beds. *Resident 21's CPAP mask was attached to the machine by a hose and was on the top of his CPAP machine. *Resident 22's CPAP mask was attached to the machine by a hose and was on her pillow. *They both indicated they had brought their CPAP machines when they were admitted to the facility "a couple of weeks ago." *Resident 22 stated prior to moving in she had cleaned their CPAP masks, hoses, and water tanks every day at home with hot water and dish soap and allowed them to air dry. *She had been unable to clean their CPAP masks, hoses, and water tanks at the facility because she could not stand at the sink long enough and did not have any dish soap. *The staff members had assisted her with adding distilled water to the tanks, "if they spot that it is low." *She thought the staff did not know that the CPAP machines and masks needed to be cleaned or how to clean them. *She stated she would have known if the staff had cleaned their CPAP masks because she felt "they are getting smelly." 2. Review of resident 21's electronic medical record (EMR) revealed:	F0695	(Continued from page 21) Residents identified to be affected by the deficient practice Residents 21 and 22 were identified to be affected by the deficient practice. How corrective action will be accomplished for those residents found to have been affected by the deficient practice Residents 21 and 22 had their CPAP machines cleaned on 7/25/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice Current residents with a CPAP machine have the potential to be affected. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing reviewed the treatment administration record (TAR) for current residents who have and use a CPAP machine to ensure a nursing order is in place to clean the CPAP as instructed by the manufacturer on 7/30/2025. Current licensed nurses were educated to follow the manufacturer's instructions for the cleaning of each CPAP machine and mask. How the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will conduct CPAP cleaning audits for current residents who have and use a CPAP machine. Audits will occur once a week for one month,	

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F0695 SS = E	Continued from page 22 *He was admitted on 6/30/25. *His diagnoses included obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked) and dementia (a group of symptoms affecting memory, thinking, and social abilities). *His 7/5/25 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated he was severely cognitively impaired. *A 7/1/25 physicians order "APAP (automatic CPap) with settings of 5-20 cm [centimeters of] H2O [water] every night." *There was no documentation in his EMR that indicated his CPAP mask and tubing were being cleaned. 3. Review of resident 22's EMR revealed: *She was admitted on 6/30/25. *Her diagnoses included obstructive sleep apnea and fracture of the right lower leg. *Her 7/5/25 BIMS assessment score was 14, which indicated she was cognitively intact. *A 7/1/25 physicians order "CPap with 8 cm of water nightly every night shift for OSA [obstructive sleep apnea]." *There was no documentation in her EMR that indicated her CPAP mask and tubing were being cleaned. 4. Interview on 7/24/25 at 12:10 p.m. with director of nursing (DON) B and administrator A regarding residents 21 and 22's CPAPs revealed: *DON B was aware that residents 21 and 22 had brought their CPAPs with them when they were admitted and that they were using them every night. *DON B expected there would be a nursing order on the residents' treatment administration record (TAR) to ensure that the CPAPs were cleaned daily between uses. *Administrator A and DON B confirmed that residents 21 and 22 did not have that nursing order on their TARs.	F0695	(Continued from page 22) then once a month for two months, to ensure licensed nurses are cleaning CPAP machines per the manufacturer's instructions. The findings will be reviewed at the monthly Quality Assurance/Performance Improvement (QAPI) meetings.	

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F0695 SS = E	Continued from page 23 *Administrator A confirmed that the provider's oxygen use policies did not address the use of CPAPs and that they would follow the manufacturer's instructions for the cleaning of the CPAP machines and masks. 5. Review of the undated ResMed CPAP manufacturer's instructions revealed: *"Regularly clean your tubing assembly, water tub and mask to receive optimal therapy and to prevent the growth of germs that can adversely affect your health." *"You should clean your device weekly as described. Refer to the mask user guide for detailed instructions on cleaning your mask. *"Wash the water tub and air tubing in warm water using only mild detergent." *"Rinse the water tub and air tubing thoroughly and allow to dry..." *"Wipe the exterior of the device with a dry cloth." 6. The provider had not provided cleaning instructions for the CPAP masks. 7. Review of the provider's November 2018 Respiratory Care: Equipment Care and Handling policy revealed it did not address the use or cleaning of CPAP machines or CPAP masks. 8. Review of the provider's December 2017 Guidelines for Administration of Aerosolized Care policy revealed it did not address the use or cleaning of CPAP machines or CPAP masks.	F0695		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F0812	(See page 25)	

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F0812 SS = F	Continued from page 24 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Follow standard food safety practices to ensure one of one kitchen had been cleaned to maintain a sanitary environment to store, prepare, and serve food to residents related to the cleanliness of the food preparation areas. *Follow acceptable food safety practices by not having ensured that food packages were dated when opened and outdated food items were discarded from inventory in one of one observed kitchen related to food items requiring refrigeration. *Properly temp foods to prevent the spread of cross-contamination by one of one observed cook M during one of one meal services. *Ensure the use of a beard net by one of one food and nutrition service (FANS) manager (F). Findings include: 1. Observation and interview on 7/21/25 at 3:30 p.m. with FANS manager F in the kitchen revealed: *He was cooking food in a pot on the stove. *He had a short beard and was not wearing a beard net. *He was the "acting" FANS manager. *FANS manager N had been on leave since June 2025.	F0812	Prairie View Healthcare Center will follow standard food safety practices to ensure: •sanitary environment to store, prepare, and serve food to current residents •food packages are dated when opened, and outdated food items are discarded from inventory •properly temp foods •the use of hair and beard nets when in the kitchen area Residents identified to be affected by the deficient practice No residents were identified to be affected. How the facility will identify other residents having the potential to be affected by the same deficient practice Current residents who eat meals served at Prairie View Healthcare Center have the potential to be affected if standard food safety practices are not followed. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur Current dietary staff was educated on: •Dietary best practice storage areas •Dietary best practice personal hygiene •Dietary best practice food service areas •Food labeling •Personal hygiene standards policy •Food storage policy •Sanitation policy •Leftover foods sanitation and infection control policy •Dietary best practice food handling	8/15/2025

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F0812 SS = F	Continued from page 25 2. Observation on 7/21/25 at 3:55 p.m. in the main kitchen revealed: *There were uncovered containers of whipped margarine labeled "Keep Refrigerated" and peanut butter on the counter near the food serving area. *Two unopened and one partially used one-pound blocks of margarine labeled "Refrigerate for best quality," were on a shelf in the rear of the kitchen. -The partially used margarine had an orangish-pink discoloration on two sides. It had not been labeled when it had been opened or with a use-by date. *Four cereal dispensers containing dry cereal, on the shelf near the three-compartment sink, were not labeled with the contents or the date they had been opened, or their use-by date. *Two open bags of dry cereal that were not labeled with the contents or the date they had been opened, or their use-by date. *The food preparation sink contained unidentifiable orange and brown pieces of food and a significant amount of coffee splatter. *A coffee machine with two plastic trays beneath it. -The trays contained at least four wet, stained, crumpled rags and a significant amount of pooled cold coffee that was not absorbed by the rags. *The counters, a white plastic scoop, and other utensils in the utensil tray adjacent to the coffee machine contained coffee splatter. *An approximately eight-inch by four-inch coffee spill was noted on the floor to the left of the coffee machine. *The walk-in refrigerator contained: -At least nine uncovered cups with an orange puree dessert. -At least 20 uncovered cups of a white creamy dessert with what appeared to be chunks of fruit. -Peas dated "7/18" that did not contain a use-by date. -Carrots dated "7/17" that did not contain a use-by	F0812	(Continued from page 25) •Safe and best practice food handling •Handwashing policy •Foodborne illness How the facility plans to monitor its performance to make sure that solutions are sustained The Administrator or designee will conduct weekly audits of the dietary department for three months. The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI).	

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F0812 SS = F	Continued from page 26 date. -Baked beans dated "5/21/25 use by 5/22/25." -"BBQ chicken" dated "5/21/25 use by 5/23/25." -A cart contained nine plastic pitchers of juice dated "7/16 use by 7/19" and ten open boxes of juice that had not been labeled with their open date, which indicated "use within seven days." *On the floor, under the metal shelf, in the walk-in freezer, were two individual frozen waffles and two ice cream cups. 3. Observation on 7/21/25 at 5:05 p.m. in the main dining room revealed: *FANS aide P poured juice from the plastic pitchers dated "7/16 use by 7/19" and the ten open boxes of juice that had not been labeled with their open date, which indicated "use within seven days" during the meal service. *He served the creamy white and orange desserts to resident at their tables. 4. Observation on 7/21/25 at 5:25 p.m. of FANS manager F in the kitchen serving area revealed he did not wear a beard net while he plated resident meals and placed them on the window ledge to be served. 5. Observation and interview on 7/22/25 at 11:27 a.m. with dietitian O and FANS manager F revealed: *Dietitian O was at the facility once a week. *Dietitian O expected that FANS manager F or any dietary staff with facial hair would wear a beard net during food preparation and serving. -She confirmed that FANS manager F had not been wearing a beard net and she provided him with one. *Dietitian O expected that boxed juice containers would be dated with the date they were opened and discarded within seven days after that. *FANS manager F confirmed that the opened boxed juice on the cart in the walk-in refrigerator had not been dated when opened.	F0812		

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F0812 SS = F	Continued from page 27 *The juice pitchers on the top shelf that appeared to be the same pitchers observed above, contained new labels dated "7/21 use by 7/24." *Dietitian O stated that she followed the food code and that juice prepared from a powdered mix was to be discarded after seven days. *FANS manager F confirmed that the carrots and peas observed in the refrigerator had been discarded, but she thought that the baked beans and BBQ chicken had been prepared and served yesterday (7/21/25) and had been mislabeled with May dates. *There had been no meal substitutions documented in June or July. 6. Observation on 7/23/25 at 11:00 a.m. with cook M and dietician O of the food temperature monitoring of food to be served at the lunch meal revealed: *Cook M took the thermometer from its protective sleeve and, without cleaning the thermometer probe, placed it into a piece of fish. *Cook M took a second thermometer from its protective sleeve and, without cleaning the thermometer probe, placed it into a second piece of fish. *Cook M removed both thermometers from the fish and placed them on the counter with the probes touching the counter. He then placed the first probe back into another piece of fish from the same tray. *Dietician O then assisted cook M with monitoring the temperatures of the vegetables and cleaning the thermometer with an alcohol wipe before and after she used it. *Cook M then removed a thermometer from its protective sleeve, cleaned that probe with an alcohol wipe, and temped the rice. Without cleaning the thermometer probe he temped the potatoes. 7. Interview on 7/23/25 at 2:25 p.m. with dietitian O revealed she: *Expected that cook M would have cleaned the food thermometer before using it, when it became soiled or touched a potentially contaminated surface like the counter, between food items, and when he was finished.	F0812		

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F0812 SS = F	Continued from page 28 *Expected that foods would be labeled to identify the item, when they were opened, and when they needed to be discarded to ensure food safety. *Expected food to be discarded by the use-by date or by the date indicated on the item. *Had been unaware that the margarine items had been left out on the counter and expected them to have been stored as the package indicated. *Confirmed there had been no menu items substituted, and therefore it was unknown if the items in the refrigerator had been mislabeled for May 2025. *She completed weekly "walk-throughs" of the kitchen and felt that the kitchen had been maintained in a sanitary manner. 8. Review of the provider's 7/21/25 menu revealed: *Oven-fried chicken and mashed potatoes had been served. *"BBQ chicken" and baked beans had not been on the menu that day or within the past three days. Review of the providers' "FANS DAILY INSPECTION" logs revealed: *The logs were completed approximately once a week. *On 5/21/25, "Food is within use by date guidelines" was marked "No." *On 6/4/25, "Food is within use by date guidelines" was marked "No." *On 6/11/25, "EVERYTHING: Covered, labeled, dated;… (date made/opened and use-by date)?" was marked "No." *On 6/25/25, "EVERYTHING: Covered, labeled, dated;… (date made/opened and use-by date)?" was marked "No." Review of the Orange Juice Blend Base manufacturer's product label revealed there was no recommendation for a use-by date. Review of the Classic Lemonade Drink Mix manufacturer's	F0812		

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F0812 SS = F	Continued from page 29 product label revealed there was no recommendation for a use-by date. 9. Review of the provider's May 2017 Food Safety and Temperatures policy revealed: *"Label, date, cool, and store any left-over food in compliance with the Food Code." *"Dispose of all food items according to the time team frames noted in the Food Code." *"Dispose of any questionable food items." *"Prior to preparing or serving food to residents the food is inspected by the Dietary Supervisor or designate to guarantee that the food is fresh and without any evidence of contamination or spoilage." *The policy did not address the cleaning of the thermometer when temping food items. Review of the provider's March 2018 Food Labeling Reference Guide for Opened Foods policy revealed: *"Area, Refrigerator…margarine…" *"Cooked leftovers…use by date 3 days after original cooking date." *"Dry items such as bulk cereal…use by 3 months after opened." *"Fruit juice…use by date 7 days after open." Review of the provider's June 2021 Personal Hygiene Standards policy revealed: *"For all employees with beards, beer guards are worn." Review of the provider's October 2017 Menus policy revealed: *"If any meal served varies from the planned menu the change is posted for the residence and on the posted menu in the kitchen and/or in the substitution log used solely for recording such changes." Review of the provider's March 2025 Food and Nutrition	F0812		

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F0812 SS = F	Continued from page 30 Service Managers job description revealed: *"Verifies compliance with both State and Federal standards of participation for long-term care facilities." *"Supervises food preparation and service; Verifies high level of food quality and compliance with food service regulations." *"Verifies high sanitation standards, Maintains current cleaning schedules."	F0812		

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	10714	A. BUILDING: _____ B. WING _____	07/24/2025

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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 programs, was conducted from 7/21/25 through 7/24/25. Prairie View Healthcare Center was found in compliance.	S 000	S 206 44:73:04:05 Personnel Training Prairie View Healthcare Center will ensure healthcare personnel have a formal orientation program that is completed within thirty days of hire and an ongoing education program annually thereafter. The orientation program and ongoing education program will include the following subjects:(1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights;(7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs;	8/15/25
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 7/21/24 through 7/24/25. Prairie View Healthcare Center was found not in compliance with the following requirements: S206, S210, S240, S296, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs;	S 206	Staff identified to be affected by the deficient practice Certified nurse aide (CNA) G, Minimum Data Set (MDS) coordinator H, licensed practical nurse (LPN) I, had no documentation that training on dining assistance, nutritional risks, and hydration had been completed. LPN I had no documentation that training on advanced directives had been completed. How corrective action will be accomplished for those staff found to have been affected by the deficient practice -Certified nurse aide (CNA) G, Minimum Data Set (MDS) coordinator H, licensed practical nurse (LPN) I completed training on dining assistance, nutritional risks, and hydration on 8/14/2025.	

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

Kayla Evans — Administrator — 8/20/2025

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S 206	Continued From page 1 (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure three of five sampled employees (G, H, and I) had completed the annual personnel training as required. Findings include: 1. Review of the provider's employee files revealed: *Certified nurse aide (CNA) G had been hired on 3/9/25. *There was no documentation he had completed training on dining assistance, nutritional risks, and hydration. *Minimal Data Set (MDS) coordinator H had been hired on 4/4/25. *There was no documentation she had completed training on dining assistance, nutritional risks, and hydration. *Licensed practical nurse (LPN I) had been hired on 3/12/25. *There was no documentation she had completed	S 206	(Continued from page 1) -LPN I received training on advanced directives on 8/14/2025 How the facility will identify other staff having the potential to be affected by the same deficient practice Current staff have the potential to be affected by the same deficient practice due to the turnover in the business office staff. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur -Current staff completed the orientation program that covered the 9 subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention;(4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights;7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting (9) Care of residents with unique needs -The current and new business office manager was educated on the requirements of a formal orientation program and an ongoing education program for healthcare personnel on 8/14/25.	

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S 206	Continued From page 2 training on dining assistance, nutritional risks, and hydration or on advanced directives. 2. Interview on 7/24/25 at 12:15 p.m. with business office manager E revealed she was unable to locate any documentation that training on dining assistance, nutritional risks, and hydration had been completed by CNA G, MDS coordinator H, or LPN I or that training on advanced directives had been completed by LPN I. Interview on 7/24/25 at 12:20 p.m. with administrator A revealed there had been turnover in the business office staff and no additional documentation was available to support the above employees had completed the required training.	S 206	(Continued from page 2) How the facility plans to monitor its performance to make sure that solutions are sustained -The administrator or designee will audit new hire orientation for healthcare personnel for three months to ensure completion of the formal orientation training covers the 9 subjects listed above. -The administrator or designee will conduct weekly audits of SNF Clinic for one month, followed by monthly audits for two months, to ensure that current staff are being assigned and completing education on the 9 subjects listed above. The findings will be reviewed at the monthly Quality Assurance/Performance Improvement (QAPI).	
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician	S 210	S 210 44:73:04:06 Personnel Health Program Prairie View Healthcare Center will ensure that staff have their health evaluations completed by a licensed professional within 14 days of hire as required. Staff identified to be affected by the deficient practice Certified nurse aide (CNA) G, Minimum Data Set (MDS) coordinator H, Licensed practical nurse (LPN) I had no documentation of completing their health evaluations by a licensed professional.	8/15/25

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S 210	Continued From page 3 assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure three of five sampled employees (G, H, and I) had their health evaluations completed by a licensed professional within 14 days of hire as required. Findings include: 1. Review of the provider's employee files revealed: *Certified nurse aide (CNA) G had been hired on 3/9/25. *MDS Coordinator H had been hired on 4/4/25. *Licensed practical nurse I had been hired on 3/12/25. *There was no documentation to support a health evaluation had been completed by a licensed health professional for any of the above employees. 2. Interview on 7/24/25 at 12:15 p.m. with business office manager E revealed she was unable to locate any documentation of a health evaluation being completed for CNA G, MDS Coordinator H, or LPN I. Interview on 7/24/25 at 12:20 p.m. with administrator A revealed there had been turnover in the business office staff and no additional documentation was available to support the above employees had been evaluated by a licensed health professional as required.	S 210	(Continued from page 3) How corrective action will be accomplished for those staff found to have been affected by the deficient practice Certified nurse aide (CNA) G, Minimum Data Set (MDS) coordinator H, Licensed practical nurse (LPN) I completed their health evaluations by a licensed professional. How the facility will identify other staff having the potential to be affected by the same deficient practice Current staff have the potential to be affected by the same deficient practice due to the turnover in the business office staff. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur -The current business office manager was educated on the requirements of a formal orientation program, which includes a health evaluation, to ensure the timely completion of the health evaluation for new hires on 8/14/25. -A section to check off the completion of the health evaluation for new hires was added to the daily morning meeting stand-up to ensure new hires complete the health evaluation within 14 days of hire on 8/15/25. How the facility plans to monitor its performance to make sure that solutions are sustained	

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S 240	Continued From page 4	S 240	(Continued from page 4)	
S 240	44:73:04:12:01 Tuberculosis Education-Healthcare Personnel A facility shall provide yearly education to all healthcare personnel on TB risk factors, the signs and symptoms of TB, and the TB infection control policies and procedures of the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of five sampled employees (D) had completed their annual required tuberculosis education. Findings include: 1. Review of the provider's employee files revealed: *Maintenance supervisor D had been hired on 8/21/23. *There was no documentation he had completed the required annual tuberculosis education. 2. Interview on 7/24/25 at 12:15 p.m. with business office manager E revealed she was unable to locate any documentation that tuberculosis education had been completed by maintenance supervisor D. Interview on 7/24/25 at 12:20 p.m. with administrator A revealed there had been turnover in the business office staff and there was no additional documentation available to support maintenance staff supervisor D had completed the required training.	S 240	The administrator or designee will audit the health files of new hires monthly for three months, then quarterly for two quarters. The findings will be reviewed at the monthly Quality Assurance/Performance Improvement (QAPI). S 240 44:73:04:12:01 Tuberculosis Education Healthcare Personnel Prairie View Healthcare Center will ensure staff complete the annual required tuberculosis education. Staff identified to be affected by deficient practice Maintenance supervisor D had no documentation he had completed the required annual tuberculosis education. How corrective action will be accomplished for those staff found to have been affected by the deficient practice Maintenance supervisor D completed the required annual tuberculosis education on 8/14/25. How the facility will identify other staff having the potential to be affected by the same deficient practice Current staff have the potential to be affected by the same deficient practice due to the turnover in the business office staff	8/15/25
S 296	44:73:07:11 Director Of Dietetic Services	S 296		

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S 296	Continued From page 5 A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status	S 296	(Continued from page 5) Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur -Current staff completed education on Infection Control and Prevention which covers tuberculosis -The infection control and prevention training was added to SNF Clinic and set to assign to staff at the beginning of each year. How the facility plans to monitor its performance to make sure that solutions are sustained The administrator or designee will audit SNF Clinic quarterly for three quarters to ensure that staff are assigned the tuberculosis education early on in the year, allowing time to complete within the annual time frame. The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI). S 296 44:73:07:11 Director Of Dietetic Services Prairie View Healthcare Center will ensure the dietary manager and at least one cook possesses a current certificate from a ServSafe Manager's Food Protection Program or equivalent approved training. Staff identified to be affected by the deficient practice FANS manager F did not have the approved Food Protection Manager certificate or ServSafe training.	8/15/25

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S 296	Continued From page 6 of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure the dietary manager and at least one cook possessed a current certificate from a ServSafe Manager's Food Protection Program or equivalent approved training. Findings include: 1. Observation and interview on 7/21/25 at 3:30 p.m. with food and nutrition services (FANS) manager F in the kitchen revealed: *He was cooking food in a pot on the stove. *He was the "acting" FANS manager. *FANS manager N had been on leave since June 2025. 2. Interview on 7/22/25 at 11:27 a.m. and again on 7/23/25 at 2:25 p.m. with dietitian O revealed: *FANS manager N and cook M both had approved ServSafe Food Protection Manager certificates. *FANS manager F did not have the approved Food Protection Manager certificate or ServSafe training. *Dietitian O confirmed that FANS manager N had been on leave since June 2025, and there had not been a second person with the approved ServSafe training to cover that role during her leave. FANS manager N was expected to return	S 296	(Continued from page 6) How corrective action will be accomplished for those staff found to have been affected by the deficient practice -FANS manager F completed the approved Food Protection Manager Certificate on 8/15/25. -A Certified Food Protection Manger was hired on and started 8/12/25. How the facility will identify other staff having the potential to be affected by the same deficient practice No other current staff have the potential to be affected by this deficient practice. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur The dietary orientation specific checklist was updated to include the requirement for FANS managers and at least one cook to have an approved Food Protection Manager Certificate. How the facility plans to monitor its performance to make sure that solutions are sustained The Administrator will audit the dietary training file quarterly to account for possible turnover, ensuring that at least one cook and the dietary manager possess a current certificate from a ServSafe Manager's Food Protection Program or equivalent approved training. The findings will be reviewed at the monthly QAPI.	

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S 296	Continued From page 7 from leave in September 2025. *Dietitian O expected two working employees to possess the required ServSafe or equivalent training, but was unaware of the facility's plan to ensure that while FANS manager O was on leave. 3. Interview on 7/23/25 at 3:03 p.m. with cook M revealed: *He had completed the ServSafe Food Protection Manager training a couple of years ago. *He had returned to his role as a cook at the facility just a couple of weeks ago, but could not recall the dates that he had "quit" or the date he had returned. 4. Interview on 7/24/25 at 12:03 p.m. with director of nursing (DON) B and administrator A revealed: *They expected two dietary employees would have possessed the required ServSafe or equivalent training. *They had not enrolled anyone else in that ServSafe training to cover FANS manager N's leave or while cook M was not working. *Cook M had resigned and had recently been rehired. *FANS manager N's leave had started on 6/16/25. 5. Review of Cook M's employment history revealed: *He was hired on 8/31/23. *His last shift worked was 6/1/25. *His re hire date was 7/5/25. *The facility had been without an employee who possessed a ServSafe or other approved training from 6/16/25 until 7/5/25. *The facility had only one employee (cook M) who possessed a ServSafe or other approved training from 7/5/25 until 7/24/25.	S 296	S 301 44:73:07:16 Required Dietary Inservice Training Prairie View Healthcare Center will ensure dietary staff completes the required dietary training within 30 days of their hire date. Staff identified to be affected by the deficient practice Cook J and FANS aide K did not have documentation of the required dietary training that needs to be completed within 30 days of hire. Corrective action taken for staff affected Cook J and FANS aide K completed the required dietary training on 8/14/25 Current dietary staff have the potential to be affected by the same deficient practice. Measures/changes to ensure deficient practice will not recur -Current dietary staff were trained on the following subjects:(1) Food safety; (2) Handwashing; (3) Food handling/preparation techniques; (4) Food-borne illnesses; (5) Serving&distribution procedures; (6) Leftover food handling policies; (7) Time and temp. controls for food prep &service; (8) Nutrition and hydration; (9) Sanitation requirements -The BOM received education on the dietary training required for new dietary staff on 8/14/2025.	8/15/25

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S 296	Continued From page 8 Review of the provider's March 2025 Food and Nutrition Service Managers job description revealed: *"Meets the qualification for a FANS Manager set by State and Federal regulation." *"Verifies compliance with both State and Federal standards of participation for long term care facilities." *"Supervises food preparation and service; Verifies high level of food quality and compliance with food service regulations." *"Verifies high sanitation standards."	S 296	(Continued from page 8) How the facility plans to monitor its performance to make sure that solutions are sustained -The administrator or designee will audit the monthly training assigned to current dietary staff in SNF Clinic to ensure that dietary staff are completing their ongoing education. -The administrator or designee will audit the monthly training assigned to current dietary staff in SNF Clinic for two quarters to ensure that dietary staff are completing their ongoing education. The findings will be reviewed at the monthly QAPI meeting.	
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure two of five sampled employees (J and K) had completed the required	S 301		

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S 301	Continued From page 9 dietary training within 30 days of their hire date. Findings include: 1. Review of the provider's employee files revealed: *Food and Nutrition Service (FANS) cook J had been hired on 5/27/25. *There was no documentation he had completed training on food safety, handwashing, foodborne illness, serving/distribution, leftovers, time/temp controls, and sanitation. *FANS aide K had been hired on 10/24/24. *There was no documentation he had completed training on food safety, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation. 2. Interview on 7/24/25 at 1:00 p.m. with FANS manager F revealed he had been unable to locate any additional documentation of dietary staff training. Interview on 7/24/25 at 12:15 p.m. with business office manager E revealed she was unable to locate any documentation that the above training had been completed by FANS cook J and FANS aide K. Interview on 7/24/25 at 12:20 p.m. with administrator A revealed there had been turnover in the business office staff and there was no additional documentation to support FANS cook J and FANS aide K had completed the required dietary training.	S 301		