PRINTED: 06/21/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 435065 B. WING 06/08/2022 NAME OF PROVIDER OR SUPPLIER

PRAIRIE ESTATES CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST

RAIRIE	ESTATES CARE CENTER	ELK POINT, SD 57025			
(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) COMPLETIO DATE	
F 000	INITIAL COMMENTS	FO	00		
	A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/6/22 through 6/8/22. Prairie Estates Care Center was found in compliance.				
	A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/6/22 through 6/8/22. Areas surveyed included quality of care, Prairie Estates Care Center was found in compliance.				

(X6) DATE LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIES PRESENTATIVE'S SIGNATURE

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 descences are cited, an approved plan of correction is requisite to continued program participation program participation.

FORM CMS-2567(02-99) Previous Versions

Event ID: 26GE1 JUN 2 1 2022

SD DOH-OLC

Facility ID: 0067

If continuation sheet Page 1 of 1

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

PRINTED: 06/21/2022 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	WEDICAID SERVICES			OMB	NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		435065	B. WING _			06/08/2022	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE				
PRAIRIE E	ESTATES CARE CENTER	1	600 SOUTH FRANKLIN ST ELK POINT, SD 57025				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		EO	00			
	CFR Part 482, Subpa Emergency Prepared Term Care Facilities,	ey for compliance with 42 rt B, Subsection 483.73, ness, requirements for Long was conducted from 6/6/22 e Estates Care Center was					
		A					
ABORATORY (DIRECTOR'S OR PROVIDER	SUPPLIER RESPECENTATIVE'S SIGNATUR	RE /	lice Presida to f Ope	a hou	(X6) DATE /	
other safeguar ollowing the d days following program partic	ds provide sufficient projecti ate of survey whether or not the date these documents a		e institution may except for nursing rsing pomes, the endies are cited	be excused from correcting providing	it is determined that re disclosable 90 days on are disclosable 14 quisite to continued	n sheet Page 1 of 1	
	Apart Act of the Con-	SD DOH-OLC					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/21/2022 **FORM APPROVED**

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 435065 B. WING 06/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST PRAIRIE ESTATES CARE CENTER ELK POINT, SD 57025 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) INITIAL COMMENTS K 000 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/7/22. Prairie estates Care Center was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities, LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER SEPRESENTATIVE'S SIGNATURE TITLE Any deficiency statement ending with an asterisk (*) deputes 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 allable to the racility. If deficiencies are cited, an approved plan of correction is requisite to continued days following the date these documents are made program participation. Event ID: 26GB FORM CMS-2567(02-99) Previous Versions Ok Facility ID: 0067 If continuation sheet Page 1 of 1 JUN 2 1 2022

SD DOH-OLC

South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 10615 06/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 S FRANKLIN ST POST OFFICE BOX 486 PRAIRIE ESTATES CARE CENTER ELK POINT, SD 57025 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Compliance/Noncompliance Statement \$ 000 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/6/22 through 6/8/22. Prairie Estates Care Center was found in compliance. S 000 Compliance/Noncompliance Statement S 000 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 6/6/22 through 6/8/22. Prairie Estates Care Center was found in compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIED RESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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