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| PRAIRIE VIEW HEALTHCARE CENTER | 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/3/24 through 6/6/24. Prairie View Healthcare Center was found not in compliance with the following requirements: F550 and F812.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/3/24 through 6/6/24. The area surveyed was a resident safety relating to fall from a van wheelchair lift. Prairie View Healthcare Center was found not in compliance with the following requirement: F689. | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the | F 550 | 1. Unable to correct deficient practices noted during survey. All residents have the potential to be affected.<br><br>2. The ED, DNS and SSD have reviewed the employee code of conduct which references resident rights by 6/28/2024. The DNS or designee will educate all staff on residents rights referencing employee code of conduct that specifically related to the right to live a dignified existence, knocking and asking to enter their room, not using nicknames that are unwarranted by the resident, transferring residents in a dignified manner, providing timely incontinence care, maintain a homelike environment by not speaking loudly and not speaking about a resident in front of another resident by 7/3/2024. All staff not in attendance will be educated prior to their next working shift.<br><br>3. The DNS or designee will audit 4 random residents weekly times four weeks and monthly times 2 months on knocking and asking to enter their room, not using nicknames that are unwarranted by the resident, transferring residents in a dignified manner, providing timely incontinence care, maintain a homelike environment by not speaking loudly and not speaking about a resident in front of another resident. The DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits. | 07/03/2024 |

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

Kayla Evans | Executive Director

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

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| F 550 | Continued From page 1<br>provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the provider failed to ensure staff interactions and services were provided in a manner that maintained a resident's sense of dignity and respect by failing to:<br>*Knock and ask permission to enter one of one sampled resident's (5) room.<br>*Refer to one of one sampled resident (27) by a preferred nickname.<br>*Follow two of two sampled resident (24 and 25) care plans for transfers in a dignified manner from their wheelchairs to their dining room chairs.<br>*Provide incontinence care to one of one sampled resident (25) prior to being transferred into a dining room chair.<br>*Maintain a homelike dining atmosphere by speaking loudly across the dining room to coworkers and other residents, and speaking | F 550 | | |

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| F 550 | Continued From page 2 | F 550 | | |

about a resident (31) in front of that resident and others during two of two mealtime observations. Findings include:

1. Observation and interview on 6/3/24 at 3:27 p.m. with resident 5 in his room revealed:
*He stated that "workers bust in the door without knocking."
*During the interview, certified nurse aide (CNA) E walked into the resident's room without knocking and interrupted the conversation.
-The door was all the way open.

2. Observation on 6/3/24 at 5:39 p.m. in the dining room revealed:
*CNA E sat down at one of the assisted dining tables and yelled across the room to another staff member.
-"Did [resident 36] eat? Did he eat?"
*CNA E and two other unidentified female staff members were also talking loudly to each other across the dining room, attempting to plan when they should take their respective breaks and where they were going to go.
-CNA E said, "Can you feed so these two can go on break?"
*CNA E was overheard asking a resident at the assisted dining table, "Is it too hot for you, baby?"
*He was speaking with resident 16 in a child-like manner, exclaiming "Good job!" when she took a bite of food.

3. Observation on 6/4/24 from 11:13 a.m. to 11:51 a.m. in the dining room during the noon meal revealed:
*CNA E transferred resident 25 from her wheelchair to a dining chair by grabbing her under her arm and the waistband of her pants and hoisted her up.

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| F 550 | Continued From page 3<br>*As resident 25 stood, her bottom was noticeably wet and soaked through, potentially with urine.<br>-CNA E touched the soiled portion of her pants with his ungloved left hand and did not wash his hands.<br>*CNA E sat resident 25 back down in her dining chair and walked away without assisting her out of the dining room to attend to her visibly wet pants.<br>*He proceeded to touch other residents' wheelchairs and walkers, to place clothing protectors on residents, and to help other residents to transfer to their dining chairs with his unclean hands.<br>*CNA E assisted resident 24 from his wheelchair to a dining room chair without first having locked his wheelchair brakes, grabbed his waistband to hoist him up and pivoted him into a chair.<br>*CNA E then used hand sanitizer at 11:27 a.m.<br>*CNA E was seated at one of the assisted dining tables and observed resident 34 walking out of the dining room.<br>-CNA E yelled out the resident's name four times.<br>-He then walked over to resident 34, and loudly said, "You need to go sit back down because you haven't eaten yet!"<br>-Resident 34 walked back over to his table, appeared to have seen his food had not been served, and walked out of the dining room.<br>*Resident 139 had propelled herself into the middle of the dining room as her oxygen cord dragged on the floor. CNA E yelled across the room, "[Resident 139], you okay?"<br>*CNAs E and F were seated at an assisted dining table and had been helping residents eat their lunch.<br>-CNA E asked CNA F, "Have you seen her [resident 31] eat by herself?" in front of that resident, other residents, and a guest. | F 550 | | |

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| F 550 | Continued From page 4<br>-CNA F responded, "No she doesn't feed herself. I've never seen her feed herself."<br><br>4. Observation on 6/4/24 at 2:50 p.m. with CNA G and resident 27 while in her room revealed:<br>*CNA G was by resident 27's bedside and had been preparing to obtain her vitals.<br>*CNA G stated, "Hey grandma, I'm going to take your vitals."<br>*Resident 27 did not say any comments about having been called "grandma."<br><br>5. Interview on 6/5/24 at 10:33 a.m. with CNA H regarding how she would have properly transferred a resident from their wheelchair to a dining room chair revealed:<br>*She stated she would have first informed the resident that she would be helping them from their wheelchair to the dining room chair.<br>*She would have then locked the wheelchair brakes and used a gait belt to have assisted the resident to stand and pivot to their chair.<br><br>6. Interview on 6/5/24 at 10:50 a.m. with nurse aide I regarding how to properly transfer a resident from their wheelchair to a dining room chair revealed:<br>*She indicated she was in CNA training.<br>*She stated she would have locked the resident's wheelchair breaks, used a gait belt, assisted the resident to stand, pivot, and sit in their dining chair, and then removed the gait belt.<br>*She would have also explained to the resident what she would be doing before she did it.<br><br>7. Interview on 6/5/24 at 12:41 p.m. with social services designee/registered nurse (RN) J regarding resident dignity and privacy revealed:<br>*She would have expected staff to knock, | F 550 | | |

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| F 550 | Continued From page 5 | F 550 | | |

introduce themselves, and ask for permission before entering a resident's room.
*She had provided staff with education and had reminded them to treat the residents with respect even if the staff were busy.

8. Interview on 6/5/24 at 1:58 p.m. with administrator A regarding resident dignity and privacy revealed:
*She would have expected staff to knock on resident's doors before entering their rooms and introducing themselves before providing care to residents.
*She would have expected staff to take residents back to their rooms if they need continence care before entering the dining room.

9. Interview on 6/6/24 at 11:14 a.m. with licensed practical nurse (LPN) K regarding resident dignity in the dining room revealed:
*When she assisted in the dining room, she would have expected staff to offer a clothing protector to the residents.
*Staff should have made sure residents' hands and faces were clean.
*Transfer belts and slings should have been removed.
*She indicated it was not acceptable for staff to have yelled across the dining room at other staff members or residents.
*She also indicated it was unacceptable for staff members to have spoken about a particular resident in front of that resident, or in front of other residents.

10. Interview on 6/6/24 at 11:25 a.m. with CNA H regarding resident dignity in the dining room revealed:
*Staff should have covered the residents with a

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| F 550 | Continued From page 6<br>clothing protector so their clothes would stay clean.<br>*She said, "When they are a 'feeder' keep them clean."<br>*She indicated it was not appropriate for staff to have talked about a resident when that resident is present.<br>*She said when communicating with other staff members, staff should not have been yelling at each other across the dining room.<br><br>11. On 6/4/24 at 3:08 p.m., a policy on resident dignity was requested. The provider indicated they did not have a policy for resident dignity.<br><br>12. Review of resident 27's current care plan revealed:<br>*There was an intervention which read, "Prefers to be called: [resident's nickname]." Date initiated and revised on 6/3/22.<br>*There was no mention of the word "grandma" in her care plan.<br><br>13. Review of resident 25's current care plan revealed:<br>*Intervention of "TRANSFER/AMBULATION: Assist x 2 and FWW for short distances. Wheelchair for long distance mobility as needed." Date initiated 9/26/22, revised on 5/28/24.<br>*Intervention of "Gait belt while ambulating, standing, transferring." Date initiated 11/9/22, revised on 2/23/24.<br><br>14. Review of resident 24's current care plan revealed there was an intervention of "TRANSFER: assist x2 staff for transfers. Assist x2 staff due to behaviors." Date initiated 2/24/22, revised on 5/22/24. | F 550 | | |

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| F 550 | Continued From page 7<br>15. Interview on 6/6/24 at 11:35 a.m. with director of nursing services B regarding maintaining resident dignity and respect revealed:<br>*Staff should have engaged with the residents to foster a homelike environment.<br>*It was inappropriate for staff to have spoken loudly across the dining room at other staff members or to other residents.<br>*It was not appropriate for staff to have talked about the residents in front of that resident.<br>*Staff should not have used pet names such as "baby" or "grandma" for residents unless that resident provided consent to do so.<br>-She confirmed that resident 27 was not CNA G's grandma and he should not have been calling her that.<br>-She indicated that some of their travel staff was from the southern region of the country, and it was a cultural thing for them to call each other by those pet names, but that was not necessarily the culture of the Midwest.<br>*She had previously spoken to CNA E about his interactions with residents and other staff members but had not seen any improvement.<br>*She confirmed residents 24 and 25 should have been transferred using a gait belt rather than by their waistband.<br>*She confirmed CNA E should have performed hand hygiene after he had touched resident 25's soiled pants with his bare hand. | F 550 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | F 689 | See next page. | |

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| F 689 | Continued From page 8<br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, and record review, the provider failed to ensure one of one sampled resident (29) was safely transferred out of the facility van while using the hydraulic wheelchair lift, which resulted in the resident sustaining injuries.<br>Findings include:<br><br>1. Review of the provider's submitted SD DOH FRI revealed:<br>*On 5/22/24 at around 5:15 p.m., resident 29 was transferred to the facility from the emergency room (ER) via the facility van.<br>*Certified nurse aide (CNA) L instructed the resident several times to keep his arms "folded in and on his lap prior to attempting [to] transfer out of the can using the [wheelchair] lift."<br>*CNA L positioned herself on the ramp with the resident.<br>*The wheelchair lift was still in the process of lowering to the ground when resident 29 reached out to grab onto the bar of the lift "causing the platform to move which caused [CNA L] and [resident 29] to tip backwards over the lift."<br>*CNA L immediately called for help, and a charge nurse and the nurse manager came outside to assist.<br>*Vitals were taken. Range of motion was within normal limits for the resident.<br>-While at the ER, he was diagnosed with a urinary tract infection and had been experiencing a decline in cognition. | F 689 | 1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected.<br><br>2. The ED, DNS and interdisciplinary team have reviewed the driver training checklist by 6/30/24. The ED or designee has completed the checklist and provided training regarding safe transport to all staff that provide transport by 7/3/2024. All staff not in attendance will be educated prior to their next working shift.<br><br>3. The ED or designee will audit 4 transports monthly times 3 months to ensure safety checklist has been followed correctly. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits. | 07/03/2024 |

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| F 689 | Continued From page 9<br>*Resident 29 reported pain in his right flank [his hip area].<br>*An abrasion was noted on the back on his head, and his right flank was reddened.<br>*His care plan was updated to have at least two staff assist during transfers using the van wheelchair lift.<br><br>2. Interview and observation on 6/4/24 at 9:58 a.m. with resident 29 while in his room revealed:<br>*He had arthritis and multiple sclerosis (MS).<br>*He briefly mentioned about his recent fall off the van and explained the van "buckled" underneath him.<br>-He fell, his wheelchair fell, and the staff fell.<br>*His right hip was hurt, and he sustained two abrasions on his head.<br>*His pointed out that his right wheelchair arm was bent. He stated that was because of the fall.<br><br>Continued interview on 6/4/24 at 4:27 p.m. with resident 29 about his accident revealed:<br>*He stated he was not taken back to the ER after his fall until about three or four days afterwards due to him having a lot of pain in his right hip.<br>*He could not remember the results of his X-rays.<br>*He talked about his upcoming orthopedic appointment to address his hip pain.<br>*When describing the accident, he stated:<br>-He was wheeled onto the ramp facing the van rather than facing out towards the parking lot.<br>-He believed that "something might not have been clipped into place."<br>-He fell backward, his wheelchair fell on top of him, and the arm was bent, then the aide fell on top of both him and his wheelchair.<br>*The resident explained he was still experiencing pain in his right hip, and he showed healing scabs on his head. | F 689 | | |

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| F 689 | Continued From page 10<br>-He explained he did not require stitches.<br>-There were two scabs on his head. One scab on the back of his head was approximately 1 centimeter (cm) by 2cm, and another scab on the right side of his head was approximately the same size.<br><br>3. Observation and interview on 6/6/24 at 8:13 a.m. with maintenance director M revealed he:<br>*Demonstrated how the van wheelchair lift operated.<br>*Confirmed the lift was in good working condition at the time of the accident.<br><br>4. Observation and interview on 6/6/24 at 8:30 a.m. with director of nursing services (DNS) B and CNA L revealed:<br>*CNA L transferred resident 29 to the ER via the facility van on 5/22/24 due to reports of nausea, vomiting, decreased appetite, diminished lung sounds, and difficulty breathing through his nose.<br>*He was diagnosed with a UTI at the ER.<br>*When CNA L brought him back to the facility, she noted he was acting confused and grabbing at random objects.<br>*She wheeled him onto the wheelchair lift. He was facing the van's interior, with his back towards the outside.<br>*She confirmed she had not locked his wheelchair wheels.<br>*Resident 29 was trying to stand up from his wheelchair to grab at the lift frame rather than the lift handrails.<br>*She confirmed the lift was partway in the air at the time he started to stand up and was approximately 1.5 to 2 feet off the ground.<br>*With the lift remote still in her hand, she climbed onto the lift with the resident to try to calm him down and have him sit in his chair. | F 689 | | |

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| F 689 | Continued From page 11 | F 689 | | |

*During that process, resident 29 "flopped" back down into his wheelchair. The momentum of the resident sitting back down caused him to tip backward off the wheelchair lift.
-The lift was still lowering to the ground at that time.
*The wheelchair landed on top of him.
*She confirmed she also fell off the lift, on top of the resident and his wheelchair.
*She immediately phoned for help.
*Staff assessed him upon arrival and assisted him back to his wheelchair.

5. Interview on 6/6/24 at 10:20 a.m. with DNS B and Minimum Data Set (MDS) Coordinator N about resident 29's accident revealed:
*DNS B confirmed that CNA L should have locked the resident's wheelchair before lowering the wheelchair lift.
*She confirmed it was not normal procedure to have the staff on the wheelchair lift with a resident as the lift was moving.

6. Review of resident 29's current care plan revealed:
*A problem area of "[Resident 29] is High risk for falls r/t [related to] Gait/balance problems, MS dx [diagnosis], hx [history] of fall." Date initiated 3/4/24, revised on 3/12/24.
*The associated interventions were as follows:
-"5/23/24- assist x2 for all transfers via facility van." Date initiated 5/23/24.
-"anti rollback wheelchair." Date initiated 5/22/24.
-"Cue and supervise as needed." Date initiated 3/12/24.
-"Educate the resident /family/caregivers about safety reminders and what to do if a fall occurs." Date initiated 3/4/24.
-"Follow facility fall protocol." Date initiated 3/4/24.

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| F 689 | Continued From page 12<br>-"OT [occupational therapy] to evaluate and treat as ordered and PRN." Date initiated 3/4/24.<br>-"Pt [physical therapy] evaluate and treat as ordered or PRN." Date initiated 3/4/24.<br><br>7. Review of resident 29's progress notes revealed:<br>*A nurse's "Alert Charting: Fall/Accident/Injury" progress note from 5/22/24 at 5:15 p.m. read in part:<br>-"Staff took [resident 29] to ER and had some difficulty having [him] keep hands in lap when using ramp to elevate [his] WC [wheelchair] into the facility van; Staff instructed Pt [patient] multiple times to keep hands in lap however Pt kept grabbing at multiple structures in reach.<br>-On return from ER Pt was being wheeled onto ramp and continued to grab at different structures despite instruction to keep hands in lap.<br>-Staff then got on ramp with Pt to assist in keeping Pt safe while ramp was lowering from back of van when ramp was approximately 2 feet off ground, Pt again grabbed at bar causing a wobble that tipped staff and Pt backwards over the lip of the ramp with ramp remote in staff hand.<br>-Staff moved immediately to move Pt to safe position and removed wheelchair from where it had tipped onto Pt; Pt moved around on ramp attempting to grab bar and staff immediately called for assistance from nurses inside.<br>-On arrival, Pt laying on platform with legs over side on ground, WC had been moved out of the way, staff was seated with Pt.<br>-Pt states: 'We flipped off the ramp.'<br>-Nurses immediately assess for injury and obtain vitals ...<br>-Pt reports being uncomfortable with lip of ramp at buttock. Nurses attempt to move Pt to a position to allow further assessment and have | F 689 | | |

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| F 689 | Continued From page 13 | F 689 | | |

some difficulty when giving Pt directions to let go of bars of ramp as Pt kept putting hands back on bars and not letting go when asked to keep hands in lap.
-It took multiple repetitions and gently disengaging Pt's hands from bar and returning them to Pt's lap so nursing able to position Pt.
-Note 1.3cm abrasion to back of head. Note redness to right flank.
-Nurse called out to Pt's niece [name redacted] to update on fall and on new order for antibiotic for UTI.
-[Resident 29's physician] updated via fax.
-Future transportation via van to have 2 staff for safety.
-Pt's niece [name redacted] reports Pt has history of difficulty following instructions due to cognition at previous facility."
*A nursing progress note from 5/23/24 at 3:05 p.m. indicated resident 29 was able to move all his extremities per his normal and continued to have a "small lump of the back of head from the fall."
*A nursing progress note from 5/29/24 at 10:20 a.m. read, "Pt reporting increased bilateral hip pain rated 7/10 and reports increased difficulty standing self and transferring ... Nurse called out to clinic to update and request instructions regarding this issue. Awaiting response."
*An appointment progress note from 5/30/24 at 10:44 a.m. read, "Res [resident] went to the [local clinic name] and had x-rays performed on bilateral hips, res was transported by staff in the company van, res returned to facility in same condition as leaving, x-ray results pending."
*A follow-up appointment progress note from 5/31/24 at 2:02 p.m. indicated that resident 29 had significant arthritis and the clinic provider recommended a referral to orthopedics.

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| F 689 | Continued From page 14<br><br>8. Review of resident 29's medical diagnoses revealed he had multiple sclerosis.<br><br>9. Review of resident 29's current physician's orders revealed he was prescribed the following pain medications:<br>*"Acetaminophen Oral Tablet 325 MG [milligrams]. Give 2 tablet by mouth every 4 hours as needed for pain, ordered on 4/8/24."<br>*"Acetaminophen Oral Tablet 500 MG, Give 2 tablet by mouth three times a day for Pain Do not exceed 3000 mg/24 hrs [hours], ordered on 3/4/24."<br>*"Diclofenac Sodium External Gel 1 %, ordered on 3/4/24."<br>*"Gabapentin Oral Capsule 100 MG, Give 2 capsule by mouth three times a day for increased leg pain 200mg TID [three times a day], ordered on 4/3/24."<br>*"Tramadol HCl [hydrochloride] Oral Tablet 50 MG, Give 1 tablet by mouth every 12 hours as needed for Pain, ordered on 4/12/24."<br><br>10. Review of resident 29's May 2024 medication administration record (MAR) revealed:<br>*He was administered the scheduled doses of acetaminophen, gabapentin, and diclofenac gel as ordered.<br>*He was administered a PRN (as needed) dose of acetaminophen on 5/23/24 at 12:57 a.m. with a pain level of 4/10 on a 0-10 pain scale.<br>*He was administered a PRN dose of tramadol on 5/23/24 at 5:10 a.m., and again on 5/30/24 at 8:00 a.m. with a pain level of 4/10 on a 0-10 pain scale on both occasions.<br><br>11. Review of resident 29's June 2024 MAR through 6/6/24 revealed: | F 689 | | |

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| F 689 | Continued From page 15<br>*He was administered the scheduled doses of acetaminophen, gabapentin, and diclofenac gel as ordered.<br>*He did not receive any PRN doses of acetaminophen.<br>*He received a PRN dose of tramadol on 6/1/24 at 7:25 a.m. with a pain level of 5/10, and on 6/5/24 at 2:49 a.m. with a pain level of 2/10 on a 0-10 pain scale.<br><br>12. Review of resident 29's May and June 2024 treatment administration record (TAR) revealed:<br>*"Monitor abrasion to back of head until resolved. every shift." Start date 5/23/24.<br>-The documentation indicated that the area was marked as "monitored" twice per day from 5/23/24 to 6/5/24.<br>*"Monitor redness to right flank every shift until resolved. every shift." Start date 5/23/24.<br>-The documentation indicated that the area was marked as "monitored" twice per day from 5/23/24 to 6/5/24.<br><br>13. Review of resident 29's electronic and paper medical record revealed there was no evidence of wound or skin assessments regarding his abrasions.<br><br>14. Review of the "Operator's Manual" for the type of wheelchair hydraulic lift used by the provider revealed:<br>*The manual was for the "NL Millennium 2 Public Use Wheelchair Lift" made by The Braun Corporation.<br>*Page 4 included a diagram of the lift. The "inboard" direction was towards the van. The "outboard" direction was towards the outside. The "pump side vertical arm" was the area the resident was attempting to hold onto rather than | F 689 | | |

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| F 689 | Continued From page 16<br>the "handrails."<br>*Page 11 included several warnings, including "Whenever a wheelchair passenger ...is on the platform, the ...wheelchair brakes must be locked, the passenger should grip both handrails (if able)."<br>*Page 12 included additional warnings, " ...Stop and brake wheelchair when loading onto the platform (manually stop and brake manual wheelchairs ...)."<br>*Page 13 included additional warnings, "Failure to follow these safety precautions may result in serious bodily injury ..."<br>*Page 21 included a note about the handrails, "Dual handrails are provided for wheelchair passenger ...use. ...If able, passengers should grip both handrails when on the lift platform ..."<br>*Page 22 included several notes about the lift attendant:<br>-"If you are an attendant operating the lift, it is your responsibility to perform safe loading and unloading procedures."<br>-"The lift operator ...must keep clear of the area in which the lift operates."<br>-"The lift attendant should not ride on the platform with the passenger."<br>*Page 22 included recommendations on positioning the passenger on the lift:<br>-"Braun NL-2 Series wheelchair lifts accommodate both inboard and outboard facing wheelchair passengers or standees."<br>-"Inboard facing of wheelchair lift passengers is not prohibited, but outboard facing of passengers is recommended by The Braun Corporation."<br>*Page 24 included additional notes about ensuring the wheelchair brakes were locked prior to operating the lift.<br>*Page 26 included a section about preventative maintenance: | F 689 | | |

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| F 689 | Continued From page 17<br>-"General preventative lift maintenance consisting of careful inspections of the list system and cleaning the lift should be a part of your transit agency's daily lift service program."<br>*Pages 28 and 30 included "Lift Operating Instructions" with pictures. There was a warning again to "Load passenger onto platform and lock wheelchair brakes."<br><br>15. Review of the provider's "Work History Report" on the van for the past 12 months revealed:<br>*The "Vehicle Inspection: Safety Inspection" was marked as completed each month.<br>*On 6/30/23, a note read, "Will schedule van for service. Needs new air filter and coolant topped off."<br>*On 12/31/23, a note read, "Van out for repairs. Will inspect upon return."<br>*On 1/31/24, a note read, "Van is out for repairs. Will inspect when it gets back before any resident transport."<br>*On 4/30/24, a note read, "Vehicle is out for service and repairs. Will inspect it when it gets back before next transport."<br><br>16. Review of the provider's documentation on their most recent wheelchair lift service revealed:<br>*The van wheelchair lift was last serviced in December 2023.<br>-The service estimate was printed on 12/4/23 and the invoice was printed on 12/28/23.<br>*A multipoint vehicle inspection was completed.<br>*A chief concern on the invoice read, "The lift drops as soon as it is deployed, deemed unsafe for use. Diagnose and advise."<br>-"Cause: Found Hydraulics worn and leaking."<br>-"Correction: Removed and replaced lift cylinders, cylinder flap and gas springs. Verified repair." | F 689 | | |

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| F 689 | Continued From page 18<br>*The repair service indicated on the report that they "performed service on the ramp & door. The service includes checking/ cleaning the vehicle's battery, battery terminals, ramp fasteners, and hardware for tightness - lubricating hinges, pinot points, door slides, and rollers." | F 689 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure necessary food safety guidelines were implemented and followed for appropriate storage and labeling of food items and for cleaning and sanitary maintenance of one of one kitchen and one of two kitchenettes.<br>Findings include: | F 812 | 1. All areas identified in the 2567 were cleaned to include plate warmer drawers, storage beneath the sink, storage beneath cold holding table, ceiling vents, metal splash guards, grease trap drawer, catch tray, top convection oven, floor beneath dishwasher and dishwasher. Expired food items and improperly stored food items were discarded. All residents have the potential to be affected.<br><br>2. ED and dietary manager in collaboration with the RD to reviewed policy and procedure about: Appropriate storage and labeling of food items, Appropriate cleaning and maintenance of the kitchen and kitchenettes by 7/1/24. The ED and dietary manager educated all dietary staff on proper storage and labeling of foods as well as cleaning and maintenance in the dietary department by 7/3/24. All those not in attendance will be educated prior to their next working shift.<br><br>3. The ED or designee will monitor all areas identified in the 2567 for proper cleaning and storage of food weekly times four weeks and monthly times four months. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits. | 07/03/2024 |

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| F 812 | Continued From page 19<br><br>1. Observation on 6/3/24 from 2:43 p.m. to 3:38 p.m. during the initial kitchen tour revealed:<br>*The water dispenser and ice machine in the dining room had a buildup of limescale in and around the machine, the metal grate was visibly rusty, and there was an unidentified black substance buildup in the catch tray. The machine was dripping water.<br>*There were wooden storage cabinets in the dining room which contained the following outdated food items:<br>-One bottle of caramel sauce with a "Best if used by" date of "15 May 2024," and an opened date of "2/8."<br>-A jar of instant coffee with a "Sell by Feb 07 ..." The year on the jar was smudged and appeared to have been either 2021 or 2024.<br>-A shaker of Mrs. Dash brand seasoning with a "Best by" date of 3/10/23.<br>*In the service window area of the kitchen:<br>-There was dust, food crumbs, and hair visible in the plate warmer drawers.<br>-The storage area beneath the sink was stained with visible white and yellow residue.<br>-There was a buildup of dust, garbage, and food crumbs beneath the serving equipment.<br>-There was a visible burnt substance, food crumbs, and dust in the napkin dispenser.<br>-The storage area beneath the cold holding table was scattered with food crumbs and garbage wrappers.<br>*The ceiling vents had a visible buildup of dust. One of the vents was directly above the food prep area.<br>*Regarding the gas range and flattop grill equipment:<br>-The metal splash guard in between the flattop grill and the gas range was visibly soiled with | F 812 | | |

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| F 812 | Continued From page 20<br>layers of burnt food.<br>-The grease trap drawer was not able to have been opened due to the amount of solidified grease and other food items in the drawer.<br>-The backsplash on the gas range was visibly soiled with splashes of burnt food.<br>-The catch tray beneath the gas range was soiled with layers of burnt food.<br>*The top convection oven was soiled with splatters of burnt food and other food crumbs. The glass door was difficult to see through due to the amount of burnt particles.<br>*There were several outdated and improperly stored food ingredient items in the baker's prep area in the kitchen:<br>-A bottle of lemon juice concentrate was sitting at room temperature. The manufacturer's label indicated to "Refrigerate after opening." The bottle was labeled as opened on "5/7."<br>-A bottle of imitation vanilla flavor with an opened date of "6/30/23" and an "Best by" date of "Sept 30 23."<br>-There was a brick of margarine sitting at room temperature and was not cool to the touch. The manufacturer's label indicated "Perishable keep refrigerated."<br>-A bottle of ground ginger with a label indicating "Best by Feb 13 23."<br>*Regarding the walk-in cooler:<br>-There was at least two containers of sour cream with a manufacturer's label indicating "Best By 05/31/2024." Those containers had a handwritten date of "4/24."<br>-There was at least one container of cottage cheese with a manufacturer's label indicating "Best If Used By May 22 24."<br>-There were several pitchers of various juices. Some of the labels did not match up with what was in the pitcher, and all the pitchers were past | F 812 | | |

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| F 812 | Continued From page 21 | F 812 | | |

the handwritten "Best By 5/20" date.
--There was a pitcher of an amber liquid that appeared to have been apple juice that was labeled as water.
--Some of the labels were missing from the pitchers and it was difficult to determine what the liquid was.
*Regarding the dishwasher room:
-It was a low-temperature chemical dishwasher.
-There was significant grime buildup on the floor beneath the dishwasher.
-The dishwasher was coated with limescale and food particle buildup.
-The inside of the dishwasher appeared to be covered in limescale and food particle buildup.
-The top of the dishwasher was covered in soap scum, limescale, and food particles.

2. Observation on 6/3/24 at 4:33 p.m. in the 200-hallway day room kitchenette cabinets revealed:
*There was an opened package of candy that was sealed with a rubber band.
-The rubber band was no longer elastic and crumbled when removed from the package.
-There was a "best by" date from 2016.
*A shaker of pepper had a printed date of 2015.
*There was a package of individual pancake syrup that had turned rock solid. There was no manufacturer's date on the package.

3. Interview and observation on 6/5/24 at 3:20 p.m. with cook D in the kitchen revealed:
*They did not use the flattop grill to cook food.
-It was used as a prep table.
-To clean the surface, he would sometimes scrape the food scraps into the grease trap drawer.
-He had difficulties opening the grease trap

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| F 812 | Continued From page 22<br>drawer due to the amount of solidified grease.<br>-He did not know when the drawer was last cleaned.<br>*He confirmed the drip tray beneath the gas range should have been cleaned monthly and after each food spill. He confirmed it was unacceptable to have that much burnt food in the tray.<br>*He indicated the convection ovens were deep cleaned with oven cleaner and a degreaser on a weekly basis.<br>*There was a cleaning checklist binder and staff were supposed to initial when task items were completed.<br>-He indicated the checklists might not have been filled out lately due to staffing shortages and their busy working schedules.<br>-Observation of the cleaning checklist binder at that time revealed there had not been any cleaning checklists filled out since January 2024.<br>*He indicated they delimed the dishwasher weekly.<br><br>4. Interview on 6/5/24 at 4:20 p.m. with dietary manager C about food storage and kitchen cleanliness revealed:<br>*Daily, he expected his staff to clean the trayline work area, wipe down the inside and outside of the steamer, sweep and mop, and clean the outside surfaces of the food preparation equipment.<br>*The gas range grates were supposed to have been cleaned weekly.<br>*He indicated he recently completed a deep clean of the kitchen which included cleaning the walls and ceiling pipes.<br>-He was not able to clean all the burnt food particles on the gas range backsplash. He indicated the tin metal might have been | F 812 | | |

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|---|---|---|---|
| | 435118 | A. BUILDING _____ B. WING _____ | C 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRAIRIE VIEW HEALTHCARE CENTER | 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385 |

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|---|---|---|---|---|
| F 812 | Continued From page 23 | F 812 | | |

discolored from use.
*He expected staff to clean their work areas as they worked.
*The ceiling vents and grease trap drawer "probably" should have been cleaned monthly.
*He confirmed the dishwasher was delimed once per month as recommended by their dishwasher maintenance representative.
*He was not aware of the state of the dishwasher with the buildup of limescale, soap scum, and food particles.
*He was not aware of the expired foods in the cooler or the baker's prep area.
-He indicated he reused the same bottle of vanilla extract and refilled the bottle from the larger jug of vanilla.
-He did not indicate whether the reused bottle was washed in between refills.
-He was not aware of the relabeling requirements when using refillable bottles.

5. Review of the provider's October 2017 Food Storage policy revealed:
*"Policy statement: Food storage areas are maintained in a clean, safe, and sanitary environment."
*Procedure:
-"1. Food storage areas are kept clean at all times."
-"...4. ...Empty food cans are not reused. Only food grade reusable containers are used for food storage."
-"...11. The manufacturer's expiration date, when available is the use by date for unopened items."

Review of the provider's April 2018 Food Labeling Reference Guide for Opened Items document revealed:
*"The manufacturer's expiration date, when

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| F 812 | Continued From page 24<br>available, is the 'use by' for unopened items. Use by dates should not exceed the manufacturer's expiration date."<br>*Under the "Refrigerator" section:<br>-"Thickened milks, thickened juices, thickened water: use by date 7 days after opened."<br>-"Potentially hazardous cold foods, including but not limited to: milk, cottage cheese, hard cooked eggs, bacon: use by date 7 days after opened."<br>-"Fruit juice, canned fruit: use by date 7 days after opened."<br>-"Sour cream, buttermilk, yogurt, cream cheese: use by date 14 days after opened."<br>-"Bulk, non-potentially hazardous foods, including but not limited to ...lemon juice ... use by date 6 months after opened.<br>*Under the "Dry Storage" section:<br>-"Spices, rice, sugar: use by date 1 year after opened."<br><br>Review of the provider's December 2009 Cleaning and Sanitizing Work Surfaces policy revealed:<br>*"All surfaces must be cleaned and rinsed. This includes walls, storage shelves, and garbage containers."<br>*"All surfaces that are in contact with food must be cleaned rinsed and sanitized. This includes counter tops and work surfaces."<br>*"Process to Clean / Sanitize Work Surfaces. Work surfaces are cleaned:<br>-1. After they are used.<br>-2. Before handling a different type of food."<br><br>Review of the provider's December 2009 Cleaning and Sanitizing Fixed Equipment policy revealed:<br>*"All surfaces must be cleaned and rinsed. This includes walls, storage shelves, and garbage | F 812 | | |

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| F 812 | Continued From page 25<br>containers."<br>*"All surfaces that are in contact with food must be cleaned, rinsed and sanitized. This includes, but not limited to, blender base, food processor base, slicer, mixer, can opener base, and microwave."<br>*"Process to Clean / Sanitize Work Surfaces. Work surfaces are cleaned:<br>-1. After they are used.<br>-2. Before handling a different type of food."<br><br>Review of the provider's September 2019 Sanitation policy revealed:<br>*"Policy Statement: The food service area is maintained in a clean and sanitary manner."<br>*"Procedure:<br>-1. Kitchens, kitchen areas, and dining areas are kept clean, free from litter and rubbish ...<br>-2. Utensils, counters, shelves, and equipment are kept clean, maintained in good repair, and are free from breaks, corrosions, open seams, cracks, and chipped areas.<br>- ...4. Ice used in connection with food or drink is from a sanitary source and is handled and dispensed in a sanitary manner.<br>- ...7. Cleaning schedules are developed by the FANS [food and nutrition services] Manager or Person in Charge.<br>-8. The FANS Manager or Person in Charge monitors compliance to the cleaning schedule.<br>- ...10. The FANS Manager maintains completed cleaning schedules for a minimum of 60 days."<br><br>A policy and procedure for cleaning the dishwasher was requested on 6/5/24. The provider indicated they did not have such a policy.<br><br>6. Review of the provider's daily, weekly, and monthly cleaning schedules for the past three | F 812 | | |

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| F 812 | Continued From page 26<br>months revealed that it appeared as though a base copy was drafted and photocopied for the past three months, with the different dates handwritten at the top of each page. The validity of the checklists could not be confirmed. | F 812 | | |

South Dakota Department of Health

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|---|---|---|---|
| | 10714 | A. BUILDING: _____ B. WING _____ | 06/06/2024 |

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| PRAIRIE VIEW HEALTHCARE CENTER | 401 S 1ST AVE WOONSOCKET, SD 57385 |

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|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/3/24 through 6/6/24. Prairie View Healthcare Center was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>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 6/3/24 through 6/6/24. Prairie View Healthcare Center was found in compliance. | S 000 | | |

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

Kayla Evans | Executive Director