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 11/05/2025

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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 11/5/25. Area surveyed included free of accident hazards related to the facility not providing appropriate care to a resident resulting in the resident having to be transferred to the hospital for radiographic imaging. Prairie View Healthcare Center was found to have past noncompliance at F689.	F0000		
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 the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, and record review, the provider failed to ensure one of one certified nursing assistant (CNA) E transported a resident with the use of the wheelchair pedals according to American Healthcare guidelines implemented by the facility, for one of one resident (1) who developed pain to her right knee, and could not bear weight on her right leg, and was transferred to the hospital emergency department (ED) for further evaluation. Findings include: 1. Review of the provider's 10/20/25 submitted FRI to the SD DOH regarding resident 1 revealed on 10/19/25 at approximately 6:30 p.m. CNA E did not follow guidelines	F0689	"Past Noncompliance - no plan of correction required"	

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	12/8/2025

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F0689 SS = D	Continued from page 1 for the use of wheelchairs implemented by the facility according to the American Healthcare Association for the resident. She developed pain to her right knee and could not bear weight on her right leg and as a result, she required an evaluation at the hospital's ED for radiographic images (X-ray). The facility did not have a policy that was specifically related to the use of wheelchairs and indicated they follow the American Healthcare guidelines for wheelchair use. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incidents. On 10/19/25 at approximately6:30 p.m. resident 1 was self-propelling herself in her w/c following the evening meal. She had foot pedals on the w/c, but the pedals were not in use at the time of the incident. Both foot pedals had been rotated to the sides of the w/c. CNA E had come from behind her w/c and provided assistance by pushing the w/c without using the foot pedals. While pushing resident 1 in the w/c CNA E had turned the corner of the hallway and her right foot had become lodged under the w/c and resulted in the wheelchair's right front wheel rolling over the resident's foot. Resident 1 had yelled "Stop" after the chair had rolled on top of her right foot and CNA E immediately stopped the w/c. CNA E had offered resident 1 an ice pack following the incident, but the resident had declined the offer. Neither CNA E nor the resident had reported the incident to the nurse. Resident 1 had no concerns following the incident until she had therapy the evening of 10/19/25. During the therapy session, resident 1 could not bear weight on her right leg because of the knee pain. The nurse was notified of the incident that occurred with resident 1 earlier in the evening, and the pain she was having in her right knee. The resident's primary care physician and power of attorney were notified of the incident. Orders were received by the physician to transfer the resident to the ER for further assessment and X-rays.	F0689		

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F0689 SS = D	Continued from page 2 Resident 1 received x-rays while she was the ED and the findings had shown Tri compartment degenerative change (deterioration of cartilage in all three major compartments of the knee joint, medial, lateral, and patellofemoral) with no fractures. Resident 1 was given a knee immobilizer for her right knee and it was to be worn as needed for comfort until the pain in her knee subsides. Resident 1 was able to bear weight on her right leg and transfer with minimal discomfort. She continued to receive physical, occupational, and skilled therapy that had begun when she was first admitted to the facility on 8/18/25. On 10/21/25 resident 1 was measured for a manual custom fit w/c. The custom fit w/c would allow the resident to have easier movement and motion. She had been using a wheelchair that belonged to the facility since her admission on 8/18/25. On 10/23/25 documentation was provided and revealed interim director of nursing (IDON) B provided one on one training with CNA E prior to her next working shift after the incident that occurred on 10/19/25. CNA E was educated on the process to report any change in condition of residents, wheelchair etiquette, and the use of foot pedals on wheelchairs. She was required and completed additional education on CareFeed (online education) on how staff make themselves aware of the resident, ask the resident for their permission to assist them prior to moving their wheelchair. Stop-Listen-then action to prevent injuries and respect resident rights and dignity. 2. Review of resident 1's electronic medical record (EMR) revealed her Brief Mental Status (BIMS) score was 15, which indicated she was cognitively intact. She was admitted to Prairie View Healthcare Center with a diagnoses of chronic kidney disease (CKD), peripheral vascular disease (narrowed or blocked arteries), major depressive disorder, morbid (severe) obesity, hypothyroidism, type 2 diabetes, and gastro esophageal reflux disease (chronic condition where the stomach contents flow back into the esophagus). Review of resident 1's most updated care plan revealed she used a four-wheel walker and a wheelchair for transfers. Resident 1 had difficulties related to	F0689		

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F0689 SS = D	Continued from page 3 activities of daily living related to CKD, frequent falls prior to admit, morbid obesity evidence-based deconditioning and weakness from recent hospitalization prior to admit. 3. Interview and observation on 11/5/25 at 10:48 a.m. with registered nurse, social services director (RN,SSD) C revealed wheelchair audits were initiated since the incident that occurred on 10/19/25. The audits were initiated on 10/23/25 by administrator A and were completed 3-5 times per week. Resident wheelchairs were noted to have large bags on the back of the wheelchair that were available to put wheelchair pedals in when not being used. 4. Interview and observation on 11/5/25 at 11:02 a.m. with resident 1 revealed she had a w/c with bilateral foot pedals that were attached to the chair. She could have self-propelled herself in her w/c, she turns the pedals to the side of the chair, so they are out of her way. Resident 1 indicated that on 10/20/25 at approximately 6:30 p.m. she was on her way back to her room after having dinner in the dining room . She stated CNA E had come from behind her and pushed her in her w/c. She stated CNA E did not ask her if she wanted help prior to pushing her. She stated as CNA E turned the corner of the hallway, her right foot had bent forward (rolling maneuver) on the floor and then was under the front wheel of the wheelchair. She stated she yelled out “stop” due to the pain from the wheel of the wheelchair rolling on top of her right foot. She indicated she did not report the incident to the nurse and assumed CNA E would have. She states she was sent to the emergency room at the hospital and received X-rays. She stated there were no fractures found. She was issued an immobilizer to wear on her right knee and leg until the pain subsides. She indicated she does not always wear the immobilizer because she needs help to put it on and stated, “I am stubborn and don’t want to ask for help but will wear it when they ask me if I want it on.” She stated staff usually ask her if she “needs a ride, but that day CNA E did not.” She received an immobilizer for her right knee to wear as needed. She states she had an order for Tylenol when she is having pain and when she asks for it, she receives it. 5. Interview and observation on 11/5/25 at 11:20 a.m.	F0689		

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F0689 SS = D	Continued from page 4 with resident 2 revealed that nursing staff always asked her if she needed assistance with being pushed in her w/c. She stated she will ask for help to be pushed in her wheelchair but is usually independent with that. The resident had been propelling herself in her room with the use of her w/c and the foot pedals had been in place. 6. Interview on 11/5/25 at 12:02 p.m. with IDON B revealed that she expected that staff stop and listen to the residents and ask them if they wanted help prior to just doing something for them. She stated the most important thing is to make sure the resident is safe and provide them dignity. 7. Interview on 11/5/25 at 1:35 p.m. with CNA F revealed wheelchair safety education was provided on 10/23/25 to all of the staff who work at the facility through Care Feed. There was also a group meeting where staff huddled together to discuss anything that needed to be shared amongst one another, she stated they had signed a form at that time indicating the education on wheelchair safety was received. She indicated that the facility purchased bags to be placed on the resident's wheelchairs for the pedals to be placed into when they are not being used and felt this was very beneficial and the residents really like them. She stated it helped keep track of the resident's wheelchair pedals, especially when a resident who self-propels themselves is not using them. 8. Interview on 11/5/25 at 12:08 p.m. with RN, minimum data set coordinator (MDS) D revealed that the w/c audits will continue 3-5 times per week through 11/26/25. The results will be brought to quality assurance and performance improvement (QAPI) and it will be determined at that time if they need to be continued. She stated that QUAPI is done every month on the last Wednesday of that month. 9. Interview and observation on 11/5/25 at 12:16 p.m. with RN, SSD, C revealed she had developed an audit form to document observations of resident's wheelchair pedals and if they are being used appropriately. She had verified large bags had been purchased for all residents to place on the back of their wheelchairs to be used for foot pedals to be placed in if not being used.	F0689		

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F0689 SS = D	Continued from page 5 10. Interview on 11/5/25 at 12:41 p.m. with physical therapy assistant (PTA) revealed the facility works with a company called Nu Motion. An employee from the company came to the facility and measured resident 1 for a manual custom fit wheelchair. 11. Interview on 11/5/25 at 1:58 p.m. with CNA E revealed she believed resident 1 was struggling on 10/22/25 at 6:30 p.m. when she was self-propelling herself in her wheelchair going down the hallway. She stated she had come up from behind the resident's wheelchair and began to push her. She stated when she had turned the corner of the hallway, resident 1 had indicated to "stop". CNA E indicated that the resident's care plan looked like she needed help. 12. Interview on 11/5/25 at 2:45 p.m. with administrator A revealed she had completed weekly wheelchair pedal audits 3-5 times per week to verify that all residents being transported in wheelchairs had footrests securely attached and used them correctly to ensure safety and comfort for residents. The audits would be evaluated at the next QUAPI meeting and determined if she will need to continue with the audits. 13. Review of the provider's implemented guidelines associated with the American Healthcare associated correlated to assisted transfer with an assistive device. Preparation steps include: *"Check the care plan." *"Explain the procedure and ask about resident preferences." *"Respect privacy and rights at all times." *"Make sure the leg rests are out of the way." *"Guidelines for pushing wheelchairs: Communication is key when pushing the wheelchair, and make sure the user is comfortable and secure in the chair." *"Be aware of the user's needs and preferences and adjust the wheelchair accordingly." 11. The provider's 10/20/25 implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/25 after record review revealed the facility had followed their quality assurance process,	F0689		

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F0689 SS = D	Continued from page 6 education was provided to all nursing care staff regarding wheelchair safety for locomotion and mobility and safety and comfort for residents, assessments and appropriate documentation of findings, interviews revealed staff understood the education provided regarding those topics, and a review of the provider's follow-up audits revealed substantial compliance. Based on the above information, noncompliance at F689 occurred on 10/20/25. Based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/25, the noncompliance is considered past noncompliance.	F0689		