PRINTED: 02/19/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		431339	B. WNG			02/	05/2025
NEW ZOOC PERSONNEL PROFILE	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		2	STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
C 000	with 42 CFR Part 485 485.605-485.645, red Access Hospitals (CA Services ("swing bed" 2/3/25 through 2/5/25 Health Care System with the following req NURSING SERVICE: CFR(s): 485.635(d)(4) A nursing care plan in current for each inpat This STANDARD is in Based on interview, in review, the provided of planning had been a care plan upon admist twenty-seven sample 8, 9, 10, 11, 12, 13, 1 20) to ensure their go discharge had been in 1. Interview on 2/4/25 regarding her dischar *She had been admit 2/1/25. *She was living at a w homeless people). *Her goal was to fill o paperwork to get fina Native American tribe *She would have bee apartment.	ch survey for compliance is, Subpart F, Subsections quirements for Critical (AH) and Long-Term Care (P), was conducted from is. Coteau Des Prairies was found not in compliance uirement: C1050. Sol) nust be developed and kept ient. not met as evidenced by: record review, and policy failed to ensure discharge part of the comprehensive ient of twenty of dipatients (1, 2, 3, 4, 5, 6, 7, 4, 15, 16, 17, 18, 19, and iels for a successful inet. Findings include: at 10:45 a.m. with patient 1 ge plans revealed: ied for pneumonia on varming house (shelter for it general assistance incial help from the local	50.5	0000		care narge ifts until ohasize sed care ferences erventior ess will patient's stant audit liance 25, with udit lity	ns
AROPATORY	(EMR) revealed:	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

CEO

02/27/2025

Craig Kantos

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.

AND PLAN OF CORRECTION IDE	OVIDER/SUPPLIER/CLIA INTIFICATION NUMBER:	A NO CONTRACTOR	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	431339	B. WING _		02	/05/2025	
NAME OF PROVIDER OR SUPPLIER COTEAU DES PRAIRIES HEALTH CARE S	SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE API	OULD BE	(X5) COMPLETION DATE	
**There was no documentation discharge planning revealed **She had a care plan initiate what her discharge planning revealed **She had a care plan initiate an agement and at risk for infections to meet a plan initiate and a care plan initiate exchange and risk for infections and to fill out paperwork with the assistance. **She had a care plan initiate exchange and risk for infections and the exchange and risk for infections and the exchange and risk for infections and the exchange planning had been always. -Implemented by the nursing service designee/case manarensure a plan had been devicted discharge planning revealed *She had been admitted on the discharge planning revealed *She had a care plan initiate management and at risk for *There was no documentation discharge planning had been almitted upon admission or stay. -Implemented by the nursing to ensure a plan had been didetermine what her discharge been or interventions to mee as the planning revealed *She had been admitted on the discharge planning revealed *She had been admitted on the discharge planning revealed *She had been admitted on the planning reveal	ge plan was to return te stated she wanted tribe for general d for impaired gas on. on that supported it during her hospital ger (SSD/CM) C to eloped to help ge goal would have it that goal. It's EMR regarding in 1/25/25. In the pelvic and chronic idiopathic id for pain falls. In that supported it during her hospital is staff and SSD/CM C eveloped to help ge goal would have it that goal. It's EMR regarding	C10	050			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		431339	B. WING _			02/05/2025	
	ROVIDER OR SUPPLIER DES PRAIRIES HEALT	H CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CO 205 ORCHARD DR SISSETON, SD 57262	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	D. 1997	
C1050	congestive heart fai *She had a care plaintolerance, risk for *There was no dock discharge planning -Initiated upon admistayImplemented by the to ensure a plan hadetermine what her been or intervention 4. Record review of discharge planning *She had been admidischarged from the *Her diagnoses incl obstructive pulmona of lung diseases that difficult to breathe). *She had a care plae exchange and pain *There was no dock discharge planning -Initiated upon admistayImplemented by the to ensure a plan hadetermine what her been or intervention 5. Review of patient *He had been admidischarged from the *He had been admidischarged from the *He had been admidupper gastrointestint *His care plan that is	e facility on 1/1/25. uded: acute/chronic lure (CHF) and pneumonia. In initiated for activity falls, and pain management. Immentation that supported had been: Ission or during her hospital e nursing staff and SSD/CM C d been developed to help discharge goal would have is to meet that goal. patient 11's EMR regarding revealed: Initiated on 9/28/24 and is facility on 10/1/24. Inded: pneumonia and chronic ary disease (COPD) (a group at block airflow and make it In initiated for impaired gas management. Immentation that supported had been: Ission or during her hospital e nursing staff and SSD/CM C d been developed to help discharge goal would have is to meet that goal. Is 3's EMR revealed: Itted on 12/14/24 and Itted with a diagnosis of an	C10	50			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE' COMPLETED	Y		
		431339	B. WING		02/05/202	25		
	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262				
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C1050	Continued From page		C108	50				
	discharge planning had all all all all all all all all all a	nursing staff and SSD/CM C been developed to help ischarge goal would have						
		ted on 1/23/25 and						
	admission included ri impaired skin integrity					al		
	discharge planning ha -Initiated upon admis stay.	sion or during her hospital						
	to ensure a plan had	nursing staff and SSD/CM C been developed to help ischarge goal would have to meet that goal.						
	pyelonephritis (kidney *His care plan that ha admission included ri comfort, risk for decre perfusion (adequacy from the ventricles in	ed on 9/25/24 and facility on 9/27/24. ed with a diagnosis of y infection) and sepsis. ad been initiated upon sk for infection, physical eased cardiac tissue of blood volume ejected exchange for carbon t the alveolar level) and						

CORRECTION	IDENTIFICATION NUMBER:	W. 2000 CO. C.		(X	COMPLETED		
	431339	B. WING_			02/05/2025		
	CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262				
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Continued From page	ge 4	C10	050				
*There was no docu discharge planning istayImplemented by the to ensure a plan had determine what his obeen or intervention. 8. Review of patient *She had been admidischarged from the *She had been admidischarged from the *She had been admidischarged from the admission included infection. *There was no docu discharge planning istayImplemented by the to ensure a plan had determine what her been or interventions. 9. Review of patient *He had been admitt with a diagnosis of pinflames air sacs in the filled with fluid). *His care plans that admission included pinpaired gas excharations.	mentation that supported had been: ssion or during his hospital enursing staff and SSD/CM Cd been developed to help discharge goal would have so to meet that goal. 12's EMR revealed: itted on 9/17/24 and facility on 9/19/24. itted with a diagnosis of low sue infection, rectal mass and hite blood cell count). had been initiated upon physical comfort and risk for mentation that supported had been: ssion or during her hospital enursing staff and SSD/CM Cd been developed to help discharge goal would have so to meet that goal. 13's EMR revealed: ted on 9/8/24 through 9/12/24 through 9/12/24 through 9/12/24 through 9/12/24 through goal comfort and inge. mentation that supported had been initiated upon physical comfort and inge. mentation that supported had been:						
hospitalization stay.	solon of during his						
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF *There was no docu discharge planning I -Initiated upon admis stayImplemented by the to ensure a plan had determine what his of been or intervention 8. Review of patient *She had been adm discharged from the *She had been adm hemoglobin, soft tiss leukocytosis (high w *Her care plan that I admission included infection. *There was no docu discharge planning I -Initiated upon admis stayImplemented by the to ensure a plan had determine what her of been or interventions 9. Review of patient *He had been admit with a diagnosis of p inflames air sacs in of be filled with fluid). *His care plans that admission included p impaired gas exchar *There was no docu discharge planning I -Initiated upon admis *There was no docu discharge planning I -Initiated upon admis *Intervention of the company of the comp	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH CARE SYSTEM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 *There was no documentation that supported discharge planning had been: -Initiated upon admission or during his hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what his discharge goal would have been or interventions to meet that goal. 8. Review of patient 12's EMR revealed: *She had been admitted on 9/17/24 and discharged from the facility on 9/19/24. *She had been admitted with a diagnosis of low hemoglobin, soft tissue infection, rectal mass and leukocytosis (high white blood cell count). *Her care plan that had been initiated upon admission included physical comfort and risk for infection. *There was no documentation that supported discharge planning had been: -Initiated upon admission or during her hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what her discharge goal would have been or interventions to meet that goal. 9. Review of patient 13's EMR revealed: *He had been admitted on 9/8/24 through 9/12/24 with a diagnosis of pneumonia (an infection that inflames air sacs in one or both lungs, which may be filled with fluid). *His care plans that had been initiated upon admission included physical comfort and impaired gas exchange. *There was no documentation that supported discharge planning had been: -Initiated upon admission or during his	A BUILDI A 31339 B. WING ROVIDER OR SUPPLIER DES PRAIRIES HEALTH CARE SYSTEM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 *There was no documentation that supported discharge planning had been: -Initiated upon admission or during his hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what his discharge goal would have been or interventions to meet that goal. 8. Review of patient 12's EMR revealed: *She had been admitted on 9/17/24 and discharged from the facility on 9/19/24. *She had been admitted with a diagnosis of low hemoglobin, soft tissue infection, rectal mass and leukocytosis (high white blood cell count). *Her care plan that had been initiated upon admission included physical comfort and risk for infection. *There was no documentation that supported discharge planning had been: -Initiated upon admission or during her hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what her discharge goal would have been or interventions to meet that goal. 9. Review of patient 13's EMR revealed: *He had been admitted on 9/8/24 through 9/12/24 with a diagnosis of pneumonia (an infection that inflames air sacs in one or both lungs, which may be filled with fluid). *His care plans that had been initiated upon admission included physical comfort and impaired gas exchange. *There was no documentation that supported discharge planning had been: -Initiated upon admission or during his	ROWDER OR SUPPLIER DES PRAIRIES HEALTH CARE SYSTEM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 "There was no documentation that supported discharge planning had been: -Initiated upon admission or during his hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what his discharge goal would have been or interventions to meet that goal. 8. Review of patient 12's EMR revealed: "She had been admitted on 9/17/24 and discharged from the facility on 9/19/24. "She had been admitted with a diagnosis of low hemoglobin, soft tissue infection, rectal mass and leukocytosis (high white blood cell count). "Her care plan that had been initiated upon admission included physical comfort and risk for infection. "There was no documentation that supported discharge planning had been: -Initiated upon admission or during her hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what her discharge goal would have been or interventions to meet that goal. 9. Review of patient 13's EMR revealed: "He had been admitted on 9/8/24 through 9/12/24 with a diagnosis of pneumonia (an infection that inflames air sacs in one or both lungs, which may be filled with fluid). "His care plans that had been initiated upon admission included physical comfort and impaired gas exchange. "There was no documentation that supported discharge planning had been: -Initiated upon admission or during his	A BULDING A STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SUMMARY STATEMENT OF DESPICIACIES SUMMARY STATEMENT OF DESPICIACIES SUMMARY STATEMENT OF DESPICIACIES SUMMARY STATEMENT OF DESPICIACIES SUSSETON, SD 57322 PROVIDER OR ALSO PROVIDER SPLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 There was no documentation that supported discharge planning had been: -Initiated upon admission or during his hospital stayImplemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what his discharge goal would have been or interventions to meet that goal. 8. Review of patient 12's EMR revealed: "She had been admitted on 9/17/24 and discharge planning had been: -Initiated upon admission or during her hospital stay. "There are plan that had been initiated upon admission included physical comfort and risk for infection. "There are plan that had been initiated upon admission or during her hospital stay. 9. Review of patient 13's EMR revealed: "He had been admitted on 9/8/24 through 9/12/24 with a diagnosis of pneumonia (an infection that inflames air sacs in one or both lungs, which may be filled with fluid). "His care plans that had been initiated upon admission included physical comfort and impaired gas exchange. "There was no documentation that supported discharge planning had been: -Initiated upon admission or during her hospital stay. "There was no documentation that supported discharge planning had been: -Initiated upon admission or during his hospital stay. -Implemented by the nursing staff and SSD/CM C to ensure a plan had been developed to help determine what her discharge goal would have been or interventions to meet that goal. 9. Review of patient 13's EMR revealed:		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.000 March 200	PLE CONSTRUCTION G	COMPLETED
		431339	B. WNG _		02/05/2025
	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262	4
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
C1050	C to ensure intervent in place to ensure his 10. Review of patient *She had been admit with a diagnosis of ac process of making a negative feeling wors *Her care plan that hadmission included ir *There was no docur discharge planning h-Initiated upon admis hospitalization stayImplementation by tl C to ensure intervent in place to ensure he 11. Review of patient *She had been admit 7/26/24 with a diagno complication of sever kidney dysfunction) a change in a person's *Her care plans that admission included remedical condition as pressure), physical compaired memory, ar action or process of a understanding througsenses).	ne nursing staff and SSD/CM ions and goals had been put is goals to return home. 14's EMR revealed: ted on 9/1/24 through 9/5/24 cute exacerbation (the problem, bad situation or ite) COPD. ad been initiated upon impaired gas exchange. Inentation that supported ad been: sion or during her the nursing staff and SSD/CM ions and goals had been put ir goals to return home. 15's EMR revealed: ted on 7/23/24 through ions of hepatorenal failure (a reliver disease that leads to indicate and altered mental status (a awareness and alertness). In addicated with a fall in blood comfort, excess fluid volume, indicated with a fall in blood comfort, excess fluid volume, indicated in thought, experience, and inentation that supported and been:	C10	50	
		ne nursing staff and SSD/CM ions and goals had been put			i said

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 50-000-00	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		431339	B. WING			02/	05/2025
	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 ORCHARD DR ISSETON, SD 57262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
C1050	12. Review of patient *She had been admit 7/2/24 for a left rib fra when one of the bone *There was no docun discharge planning ha -Initiated upon admiss hospitalization stayImplementation by th C to ensure interventi in place to ensure her long-term care facility 13. Review of patient *He had been admitte 6/21/24 with a diagno kidney infection). *His care plans that ha admission included prinfection. *There was no docum discharge planning ha -Initiated upon admiss hospitalization stayImplementation by th C to ensure interventi in place to ensure his returning home. 14. Review of patient *She had been admitt with a diagnosis of pr *Her care plan that ha admission included in	r goals to return home. 16's EMR revealed: ted on 6/28/24 through toture (an injury that occurs es in the rib cage cracks). hentation that supported ad been: sion or during her the nursing staff and SSD/CM tons and goals had been put r goals to be admitted to a 17's EMR revealed: ed on 6/18/24 through this is of pyelonephritis (a and been initiated upon thysical comfort and risk for the nursing staff and SSD/CM tons and goals had been put to goals to be admitted 18's EMR revealed: ted on 6/4/24 through 6/7/24 the ted on 6/4/24 through 6/7/24	C1	050			
	-Initiated upon admiss						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		431339	B. WING		02/05/2025
AMATA AM	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262	
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C1050		ne nursing staff and SSD/CM ons and goals had been put	C105	50	
	5/16/24 with a diagnor condition in which a prinflamed, narrow and mucous, which make exacerbation. *Her care plan that has admission included in *There was no document discharge planning has limitated upon admission stay. -Implementation by the	ted on 5/14/24 through sis of an asthma (a person's airway becomes swell, and produces extra s it difficult to breathe) ad been initiated upon apaired air exchange. anentation that supported ad been: sion or during her the nursing staff and SSD/CM ons and goals had been put			
	4/1/24 with a diagnost pregnant. *Her care plans that hadmission included fland nutrition. *There was no documed discharge planning had related upon admission hospitalization stay.	ted on 3/29/24 through is of pyelonephritis while and been initiated upon uid volume deficient, falls, mentation that supported ad been: sion or during her the nursing staff and SSD/CM ons and goals had been put			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/19/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	#:54###################################	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		431339	B. WING _		، ا	02/05/2025	
	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262			
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C1050	Continued From pag	e 8	C10	50			
	with diagnoses of CO infection, and CHF. *His goal had been to care at the assisted this care plan was in the nursing staff and focus areas: -High risk for falls. -Mobility. -Risk for impaired skalmaired gas exchated the was no document of the comparing the stay. -Implemented by the service designee/casensure interventions	ted to swing bed on 1/31/25 DVID-19, urinary tract o return to his prior level of living center (ALC). nitiated upon admission by had included the following tin integrity. nge. mentation that supported		Type to	ext here		
	and was discharged *His discharge plans the time of admission *He had been admitt rib fracture, atrial fibr and a removal of a n shoulder area.	need to swing bed on 7/30/24 from the facility on 9/20/24. It had been undetermined at the facility of the fac				2.	
	-Impaired physical m						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		N 8	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		431339	B. WING		02/	05/2025			
	ROVIDER OR SUPPLIER DES PRAIRIES HEALT	H CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
C1050	discharge planning -Initiated upon adm stayImplemented by th to ensure a plan ha determine what his been or intervention 19. Review of patie *He had been admi and discharged fror *He had been admi CHF, acute onset o diabetes mellitus. *His goal was to ret functioning at the A *His care plan was the nursing staff and - Impaired physical -Risk for fallsTissue integrity: Sk *There was no dock discharge planning -Initiated upon adm stayImplemented by th SSD/CM C to ensur been put in place to to return to the ALC 20. Review of patier *He had been admit and discharged und on 7/12/24. *He had been admit severe side and bac	umentation that supported had been: ission or during his hospital enursing staff and SSD/CM C dependence developed to help discharge goal would have as to meet that goal. Int 6's EMR revealed: Itted to swing bed on 12/23/24 in the facility on 1/27/25. Itted with the diagnoses of finigh blood pressure, and urn the his prior level of LC. Initiated upon admission by diad included: Imobility. In & mucous membranes. Immentation that supported had been: Itsision or during his hospital enursing staff and the receive interventions and goals had ensure he reached his goal	C105						

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		431339	B. WING			02/05/2025
	ROVIDER OR SUPPLIER DES PRAIRIES HEAL	TH CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP COL 205 ORCHARD DR SISSETON, SD 57262	ΣE	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
C1050	the nursing staff a -Impaired physica -Physical comfort. *There was no do discharge planning -Initiated upon add stayImplemented by the SSD/CM C to ensimple to discharge at his Interview on 2/5/2 officer (CNO) A, at (ACNO) B, and SS at the started at the patient and	I mobility. cumentation that supported g had been: mission or during his hospital the nursing staff and the ure interventions and goals had to ensure he reached his goal s prior level of function. 5 at 2:25 p.m. with chief nursing issistant chief nursing officer SD/CM C revealed: charge planning should have ent's admission and should of the patient's initial care plan. If were to initiate the patient's lamission and had addressed erns at that time. but have access to the patients' ate a focus area or edit them ent's hospital stay. It it is to spital stay. It is to spital stay spital stay spital stay. It is to spital stay spital stay spital stay. It is to spital stay	C10	050		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.5	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER DES PRAIRIES HEALTH	CARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262	6
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
C1050	*"Social Service/Disc are to be initiated at the patient's hospitalian patient/family outcome re-hospitalization rate *The Social Service/Distypically performed Worker Designee." Review of the provided Documentation by Exercised: *Diagnosis/Planning: -"The care plan is to be shift of admission by	er's revised 10/28/24 Swing Bed policy revealed: harge Planning interventions he earliest possible time in zation to optimize positive les and reduce les. Discharge Planning process by a Social Worker/Social ler's revised March 2024 leception & Care Plan policy lose initiated within the same the RN [registered nurse]." I ventions which will help the	C105		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WELLNESS ADDITION - BUSINESS OCCUPANCY			(X3) DATE SURVEY COMPLETED	
		431339	B. WNG			02/04/2025	
NAME OF PROVIDER OR SUPPLIER COTEAU DES PRAIRIES HEALTH CARE SYSTEM				STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	for compliance with 4 requirements for Critiswing bed). Coteau D	ey was conducted on 2/4/25	К	000			
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Craig Kantos

CEO

02/20/2025

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 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		431339	B. WING		02/04/2025	
NAME OF PROVIDER OR SUPPLIER COTEAU DES PRAIRIES HEALTH CARE SYSTEM				STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR SISSETON, SD 57262		9
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
E 000	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		E	000		
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Craig Kantos

CEO

02/20/2025

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FORM APPROVED 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: _ 60020 02/05/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 ORCHARD DR **COTEAU DES PRAIRIES HEALTH CARE SYSTEM** SISSETON, SD 57262 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 Compliance/Noncompliance Statement S 000 A licensure health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 2/3/25 through 2/5/25. Coteau Des Prairies Healthcare System was found in compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Craig Kantos

CEO

02/20/2025

PRINTED: 02/19/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000	(2) MULTIPLE CONSTRUCTION . BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
43133		431339	B. WING	B. WING			02/04/2025	
NAME OF PROVIDER OR SUPPLIER COTEAU DES PRAIRIES HEALTH CARE SYSTEM				205 ORCH SISSETO				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 000	for compliance with a requirements for Crit swing bed). Coteau I	rey was conducted on 2/4/25 42CFR 485.623(d)(1), ical Access Hospitals (and Des Prairies Healthcare was found in compliance.	K	000				
ABORATORY	NIRECTOR'S OR DROVINGE	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE	

Craig Kantos

CEO

02/20/2025

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 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.