## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		435099	B. WNG			C 04/03/2025	
NAME OF PROVIDER OR SUPPLIER  ESTELLINE NURSING AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  205 FJERESTAD AVENUE EAST  ESTELLINE, SD 57234				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A recertification healt with 42 CFR Part 483 for Long Term Care fa 4/1/25 through 4/3/25 Center was found in complaint health su CFR Part 483, Subpaterm Care facilities withrough 4/3/25. Areas resident neglect related	h survey for compliance , Subpart B, requirements notifies was conducted from . Estelline Nursing And Care compliance.  Treey for compliance with 42 rt B, requirements for Long as conducted from 4/1/25 as surveyed included potential and to a resident being left on and period of time. Estelline		0000			
ABODATORY	NIBECTOR'S OR DROVINERIS	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

Jason Hanssen

Administrator

4/11/2025

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  B. WING			(X3) DATE SURVEY COMPLETED	
	435099		B. WING				1/03/2025	
NAME OF PROVIDER OR SUPPLIER  ESTELLINE NURSING AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  205 FJERESTAD AVENUE EAST  ESTELLINE, SD 57234				
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 000	CFR Part 482, Subpa Emergency Prepared Term Care facilities w Estelline Nursing and compliance.	ey for compliance with 42 art B, Subsection 483.73, iness, requirements for Long ras conducted on 4/3/25. Care Center was found in		000				
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE .		TITLE		(X6) DATE	

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

Event ID: H3SJ21

days following the date these documents are made available to program participation. Administrator

4/11/2025

Jason Hanssen

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
	<b>435099</b> B. V			B. WING			04/03/2025	
NAME OF PROVIDER OR SUPPLIER ESTELLINE NURSING AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  205 FJERESTAD AVENUE EAST  ESTELLINE, SD 57234				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	for compliance with 4 requirements for Long	ey was conducted on 4/3/25 2 CFR 483.90 (a)&(b), g Term Care facilities. I Care Center was found in	K	000				
BORATORY (	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR	PF .		TITLE		(X6) DATE	

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.

Jason Hanssen

Administrator

4/11/2025

PRINTED: 04/09/2025 **FORM APPROVED** South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_\_ B. WNG 10617 04/03/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 FJERESTAD AVE E POST OFFICE BOX 130 **ESTELLINE NURSING AND CARE CENTER** ESTELLINE, SD 57234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted on from 4/1/25 through 4/3/25. Estelline Nursing And Care Center was found in compliance. S 000 S 000 Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/1/25 through 4/3/25. Estelline Nursing And Care Center was found in compliance.

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

Jason Hanssen

TITLE Administrator

(X6) DATE 4/11/2025