South Da	akota Department of H	ealth			FORM APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		41916	B. WING		C 01/08/2025	
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
EDGEWO	OD PRAIRIE CROSSING	S MITCHELL LLC	WISCONSIN ELL, SD 57301			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
S 000	Compliance Stateme	ent	S 000			
S 331	A licensure survey for Administrative Rules 44:70, Assisted Living assisted living center Edgewood Prairie Cr found not in compliant requirement: S331 A complaint survey for Administrative Rules 44:70, Assisted Living assisted living center Areas surveyed includeveloped a wound a discharged. Edgewood LLC was found in contact the edge of th	or compliance with the of South Dakota, Article g Centers, requirements for rs, was conducted on 1/8/25. cossings Mitchell, LLC was note with the following or compliance with the of South Dakota, Article g Centers, requirements for rs, was conducted on 1/8/25. ded a resident who had and a resident who had and a resident who had been od Prairie Crossings Mitchell, impliance. Trequirements for healthcare into are as follows: personnel or resident shall indual TB risk assessment and the two-step method of a TB blood assay test to within twenty-one days of the sion to a facility. Any two in skin tests completed in period prior to the date of ment are considered assay test completed within the prior to the date of ment is an adequate sting or TB blood assay tests new healthcare personnel	S 331	All residents will have a Tuberculin skin test completed within 21 days of admission. The licensed staff personnel to include LPI RN and or Clinical Services Director will ensure that admissions have the 2 step TB test completed within 21 days of admission by completing the appropriate forms. The forms will be uploaded to the resident electronic health record. If a documented 2 step is completed within the 12 months prior to admission, appropriate documentation will be uploaded to the resident electronic health record. The Clinical Services Director will audit all new admissions for compliance bi-weekly for one quarter and then quarterly after that 12/31/25. Results of the audit will be discussed at the monthly QI meetings. All resident health records will be audited for the appropriate Tuberculin test or documentation by 1/31/25. Any resident whose not have one on record will have a 2 step TB test completed by 2/21/25.	t until	

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

(X6) DATE

	akota Department of H	lealth			FOR	RM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
				41916	0.	C 01/08/2025
	PROVIDER OR SUPPLIER	GS MITCHELL LLC 2201 N	ADDRESS, CITY, STATE WISCONSIN ELL, SD 57301	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S 331	documentation from facility, healthcare polast skin or blood assembled within the testing or TB blood as if documentation is phealthcare facility, he resident, of a previous test. Any healthcare has a newly recognization of the presence or absence or ab	the if the facility received the transferring healthcare ersonnel, or resident, of the say TB testing having been a prior twelve months. Skin assay tests are not necessary provided by the transferring ealthcare personnel, or us positive reaction to either personnel or resident who need positive reaction to the ay test must have a medical test X-ray to determine the earth of the active disease; Rule of South Dakota is not be sure nine of nine newly 1,2,3,4,5,6,7,8 and 9) had a corculin (TB) skin test (a test TB infection) or test (a blood test used to be cition) completed within 21 indings include: 1 "s electronic medical ed: 1 "s electr	S 331			

South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C 41916 B. WING 01/08/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2201 N WISCONSIN EDGEWOOD PRAIRIE CROSSINGS MITCHELL, LLC MITCHELL, SD 57301 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 331 Continued From page 2 S 331 *She had been admitted to the facility on 9/4/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 4. Review of resident 4's EMR revealed: *She had been admitted to the facility on 9/19/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 5. Review of resident 5's EMR revealed: *She had been admitted to the facility on 9/26/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 6. Review of resident 6's EMR revealed: *She had been admitted to the facility on 10/3/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 7. Review of resident 7's EMR revealed: *She had been admitted to the facility on 10/22/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 8. Review of resident 8's EMR revealed: *She had admitted to the facility on 11/5/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 9. Review of resident 9's EMR revealed: She had been admitted to the facility on 11/12/24. *No documentation of a Mantoux skin test or a quantiferon-TB gold test had been completed. 10. Interview on 1/8/25 at 2:00 p.m. with executive director A regarding resident TB screening revealed: *She agreed that there had been no documentation of any TB testing completed on

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		41916					
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE	1 0	1/08/2025	
EDGEWO	OD PRAIRIE CROSSIN	NGS MITCHELL, LLC 2201 N	WISCONSIN ELL, SD 57301				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	HOULD BE COMPLETE	
S 331	for newly admitted i	s. a policy regarding TB testing residents, and she would have tota rules and regulations for	S 331	DEFICIENC	Y)		