

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

PRINTED: 08/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2021
NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
(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
F 000	INITIAL COMMENTS Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/9/21 through 8/12/21. Prairie Heights Healthcare was found not in compliance with the following requirements: F578 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/9/21 through 8/12/21. Areas surveyed included quality of care, staffing, resident rights, and therapy. Prairie Heights Healthcare was found not in compliance with the following requirement: F561.	F 000	Aberdeen Plan of Correction for Annual Survey of 8/12/21. The statements on this plan of correction are not admittance to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561	F561 1)Residents 12,18,33, & 66 were informed of current scheduled bath/shower days/time. Inquired if they agreed with current schedule or if they had a different preference; consent signed indicating their preference. Bath/shower preferences adjusted into the task list for EMR. Unit manager did complete by 8/31/21. 2)All current residents have the potential to not be receiving a bath/shower according to their preference day/time. Nursing management will review shower/bath schedule with current residents with a consent form completed indicating their preferences. These preferences will be adjusted into the task list for EMR. Completed by 9/3/21.	9/8/21

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

Darcy Albrecht

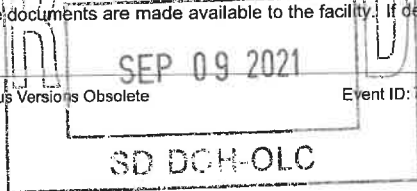
TITLE

Administrator

(X6) DATE

9/2/21

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 561	<p>Continued From page 1</p> <p>with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 29354</p> <p>Based on observation, interview, and record review, the provider failed to ensure 4 of 18 sampled residents (12, 18, 33, and 66) had received bathing per their preferences. Findings include:</p> <p>Surveyor 44928</p> <p>1. Interview on 8/10/21 at 3:03 p.m. with resident 18 regarding her bath preferences revealed: *"They changed my bath from afternoon to evenings without a choice." *"I like my bath in the morning before lunch." *"Some weeks I don't get more than one a week."</p> <p>Surveyor 43844</p> <p>Review of resident 18's bath records from 7/14/21 through 8/9/21 revealed: *The days of her scheduled baths had not been identified on the electronic medical record (EMR). *The director of nursing (DON) master paper bath schedule and the Minimum Data Set (MDS) coordinator's paper bath schedule showed she was to have received a bath on Mondays and Thursdays. *Bathing had been documented as being completed four times. -Not applicable had been documented twice.</p>	F 561	<p>3)Going forward with future residents and room changes, the staff nurse will review the shower/bath schedule with the resident and complete a consent form indicating the resident's preferences. These preferences will then be updated on the task list for the EMR by the staff nurse.</p> <p>4) Director of Nursing or Designee will educate all nurses on the above process by 9/3/21.</p> <p>5)Director of Nursing or Designee will audit 5 residents/week for a total of 8 weeks to validate preference of shower/ bath days/time are being accommodated. Director of Nursing will bring these audits to monthly QAPI for review. At this time a decision will be made for the audits to either continue or be resolved</p>		

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F 561	<p>Continued From page 2</p> <ul style="list-style-type: none"> -A refusal had been documented once. -Skin assessments had been completed four times, one of which was on the same day as a bath. <p>2. Review of resident 12's bath records from 7/16/21 through 8/10/21 revealed:</p> <ul style="list-style-type: none"> *The days of her scheduled baths had not been identified in the EMR. *The days of her bath on the DON's master paper bath schedule showed she was to have received a bath on Tuesdays and Saturdays. *The days of her bath on the MDS coordinator's paper bath schedule showed she was to have received a bath on Tuesdays and Fridays. *Bathing had been documented as being completed five times. -Two baths had been documented on Mondays, two baths on Tuesdays, and one bath on Friday. -Not applicable had been documented once. -A refusal had been documented once. -She had received five out of eight possible baths. <p>3. Review of resident 33's bath records from 7/13/21 through 8/10/21 revealed:</p> <ul style="list-style-type: none"> *The days of his scheduled baths in the EMR, the DON's master paper bath schedule, and the MDS coordinator's paper bath schedule all showed he was to have received a bath on Tuesday's and Friday's. *Bathing had been documented as completed five times. -Two baths had been on Tuesdays and three baths had been on Fridays. -Not applicable had been documented three times. -There had been no other documentation of baths received or refused. 	F 561			

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F 561	<p>Continued From page 3</p> <p>-He had received five out of nine possible baths.</p> <p>4. Review of resident 66's bath records from 7/16/21 through 8/8/21 revealed: *The days of his scheduled baths in the EMR, the DON's master paper bath schedule, and the MDS coordinator's paper bath schedule all showed he was to have received a bath on Sundays and Wednesdays. *Bathing had been documented as completed four times. -Two of the baths had been on Mondays and one of the baths had been on a Friday. -Only one of the baths had been on a Sunday (his preference). -He had received four out of seven possible baths.</p> <p>Surveyor 44928</p> <p>5. Interview on 8/12/21 at 8:16 a.m. with certified nursing assistant (CNA) C regarding the resident bath schedule revealed: *They followed a "bath list." *The not applicable (NA) documented in the EMR indicated the bath had not been listed on the paper bath schedule. *Residents usually received a couple of baths each week. **If we don't get the baths done on the day shift then evenings will do them." **We are good about getting the showers done."</p> <p>Surveyor 43844</p> <p>Interview on 8/12/21 at 8:59 a.m. with DON B regarding bathing of residents revealed: *All residents should have received at least two baths per week unless they wanted something different. *CNAs documented all baths given in the EMR.</p>	F 561			

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F 561	<p>Continued From page 4</p> <ul style="list-style-type: none"> *No one should have been using the paper bathing schedule. *When "not applicable" was documented it "meant they were out of the building or they had refused." -When the bath was documented as not applicable or refused, the EMR would not have shown the bath still needed to be completed. *The CNAs would verbally tell the next shift if they had not given a specific bath. *Whoever gave the bath should have documented it in the EMR. *The EMR would have 'flagged' if a bath had not been documented. -Someone would have followed up if it had been 'flagged' by the EMR system. *When a resident had been moved from one room to another the nurse would have changed the bath schedule in the EMR. *The paper bath schedule was: <ul style="list-style-type: none"> -A 'baseline' using the facility's room numbers as a guide for new admissions, and should not have been changed. -To be used for new residents until their preferences for bathing were identified. *Someone should have identified the EMR needed to be changed if it was not correct. *The MDS coordinator would have asked what the resident's preference had been when she completed section F of the MDS,. <p>Interview on 8/12/21 at 9:22 a.m. with MDS coordinator F regarding residents' bathing preferences revealed:</p> <ul style="list-style-type: none"> *Residents received at least two baths per week unless they requested something different. *She had updated the paper bath schedule at various times and would have put it in the CNA communication book. 	F 561			

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F 561	<p>Continued From page 5</p> <p>*Each unit had a paper bath schedule to follow. *CNAs used the paper bath schedule to know when a bath had been scheduled. *When "not applicable" was documented in the EMR it indicated "maybe they (CNAs) were charting wrong." *When a resident refused a bath, the procedure had been to offer them a bath at a different time or on a different day. -This would have been documented in the EMR. *Physical therapists and occupational therapists had assisted residents with baths. *A CNA would have documented the bath in the EMR. *A newly admitted resident would have their first bath on the scheduled day for their room, unless, they had not had one in a while. *Skin assessments would have been completed when a resident had a bath, and could be used to identify if a resident had a bath when the EMR did not indicate one had been given.</p> <p>Surveyor 44928 Interview on 8/12/21 at 9:33 a.m. with activities director D regarding the MDS assessment for all residents revealed she: *Completed the MDS assessment on resident's preferences for bathing. *Would tell the CNA what the resident preferred. *Was not responsible to care plan bathing. *Did not know who updated in the EMR for bathing preferences.</p> <p>Surveyor 43844 Interview on 8/12/21 at 10:18 a.m. with social worker Q regarding bathing of residents revealed: *When a resident was admitted to the facility their bath had been scheduled according to their room number.</p>	F 561			

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F 561	Continued From page 6 *The CNAs had a book at the nurses' station that had the room number and day of the week for each resident's bath. *Residents were able to ask to have their bath day changed. *When baths were not completed as scheduled they had been moved to the next shift. *When the staff notified her a resident refused a bath she would talk to the resident and find out why they had refused. *When a resident had notified her they had not received their bath she would have talked to the nursing staff and had them give the resident a bath at that time or the next day. *She was unsure how often baths had not been completed as scheduled. *When not applicable had been documented it "possibly meant the bath had been offered but refused." *Changes to the resident's bathing preferences would have been updated in the EMR every morning during the supervisors' morning meeting. 6. Review of providers 2018 Bath, Shower/Tub policy and procedure revealed documentation should have been completed including the date and time the bath was given.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578	F578 1) Resident #273- Code status was updated by social service designee per resident preference on 8/12/21. 2) Social Service Designee was educated by the Director of Nursing on the expectation of follow through when obtaining advance directive orders on 8/13/21.	9/8/21

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F 578	<p>Continued From page 7</p> <p>services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 43021</p> <p>Based on record review, interview, and policy review, the provider failed to ensure an advanced directive matched the residents' preference for one of eighteen sampled residents (273) who had been admitted to the facility within the past thirty</p>	F 578	<p>3)All current residents have the potential of having an incorrect code status and or a code status identifier (code status indicated in front of chart, colored dot on outside of chart, and or code status being listed in point click care.) An audit of all current residents was completed by Social Service Designee on 8/16/21 to ensure correct status and code status identifier was in chart.</p> <p>4)IDT reviewed and revised current Advance Directive policy to ensure resident code status is clearly communicated to staff on 8/18/21.</p> <p>5)Social Services will educate licensed nurses on updated advance directive policy by 9/3/21.</p> <p>6)Social services will implement an ongoing tracking log for all new admissions to ensure the advance directives/life sustaining forms and the wishes of the residents are followed through in its entirety.</p> <p>7)Social Services or designee will audit 2 charts/week for 8 weeks to ensure accuracy. Social services will bring audits to monthly QAPI.</p> <p>8)QAPI meets monthly. Audits will be brought to meeting for review by the QAPI team. At this time a decision will be made for the audits to either continue or to be resolved.</p>	

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F 578	<p>Continued From page 8 days. Findings include:</p> <p>1. Review of resident 273's electronic medical record revealed: *She was admitted on 8/5/21. *On: -8/5/21 admission and baseline care plan/summary identified her as being oriented to person, place, time, situation, and cognition intact. -8/5/21 active physician's order for full code. -8/6/21 there was a social services progress note stated "She can express her needs and make her own decisions. She states she does have a advance directive and her choice is to be a DNR [Do Not Resuscitate]. She came with a full code order. I did fax a request to her MD [Medical Doctor] for a DNR order. . ."</p> <p>Review of residents 273's paper medical chart revealed: *A red dot sticker on the exterior of the medical record. *An admission baseline care plan with a code status handwritten "No Code" (not to revive or sustain a resident who experienced a life-threatening event).</p> <p>Interview on 8/12/21 at 9:19 a.m. with social worker (SW) Q regarding resident 273's code status revealed: *During the admission process when completing the admission paperwork she reviewed: -Resident's preference for code status. -Whether request for full code, resuscitation or no code, no resuscitation, forwarded a fax request for an order to the physician. *Either she or a nurse would follow-up on the fax returned by the physician.</p>	F 578			

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F 578	<p>Continued From page 9</p> <p>*A blue dot sticker on the exterior of the medical record signified a full code.</p> <p>*A red dot sticker on the exterior of the medical record signified do not resuscitate.</p> <p>*While waiting for physician orders, the resident remained a full code.</p> <p>*She confirmed the electronic medical record for resident 273 had an active physician's order for "Full Code" and her paper medical record had a red dot sticker on the exterior that signified "No Code."</p> <p>*On 8/6/21 she had faxed a request for "DNR" after her conversation with her and anticipated an order placed the red dot sticker.</p> <p>Interview on 8/12/21 at 9:59 a.m. with director of nursing (DON) B regarding advance directives revealed:</p> <p>*The facility SW was responsible for advance directives.</p> <p>*The charge nurse would receive the fax returned by the physician and place the physician's order into the electronic medical record.</p> <p>*The facility nurses looked first for the advance directive in the electronic medical record as it was readily available.</p> <p>*If the code status was not in the electronic medical record, the nurse would look at the resident's paper medical chart for the red or blue dot sticker.</p> <p>Follow-up interview regarding resident 273's advance directive on 8/12/21 at 10:25 a.m. with SW Q revealed she had updated the resident's advance directive in the electronic medical record to "DNR/DNI [Do Not Intubate]."</p> <p>Review of the provider's undated Advance Directive policy revealed:</p>	F 578		

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F 578	Continued From page 10 **Life[-]sustaining form/advanced directives to be completed on [the] day [of] admission or next working day after admission by [the] social worker or designee. . ." **"Documentation prepared by social worker or designee based off family/resident wishes, sent to primary physician to obtain order." **"Once order is obtained and processed by nursing staff, social services or designee will mark exterior of [the] chart with appropriate code status and update code status profile in point click care [electronic medical record]." **"Blue will be designated for full code, red will be designated as DNR."	F 578		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880	F880 1) All nursing staff including professional nurses, UMAs and CNAs are identified to be at risk of the following: a)Inappropriate hand hygiene and glove use b)Inappropriate maintenance and sanitation during use of oximeter c)Inappropriate maintenance/ storage of catheter bag, tubing, and oxygen tubing 2)Staff members E,G, I and P were educated by DON on appropriate hand hygiene, glove use, appropriate storage and sanitation of oximeter, and appropriate maintenance of catheter bag, tubing, and oxygen tubing by 8/31/21. 3)IDT reviewed current policies on hand hygiene, glove use and cleaning/storing of multiple patient use equipment and discussed Root Cause Analysis on 8/31/21. No break in systems identified.	9/8/21

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NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
(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	
F 880	<p>Continued From page 11 accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>	F 880	<p>4) Root Cause Analysis fishbone completed and reviewed, including conversation highlights, in collaboration with SD Quality Improvement Organization by DON on 9/1/21.</p> <p>5) Will educate all professional nurses, UMAs, and CNA's by 9/5/21 on the following:</p> <ul style="list-style-type: none"> a) appropriate hand hygiene and glove use b) appropriate maintenance/storage of catheter bag, tubing and oxygen tubing c) appropriate maintenance and sanitation during use of oximeter <p>6) DON or designee will audit 5 professional nurses, UMAs and or CNAs per week for 8 weeks to ensure appropriate hand hygiene, glove use, maintenance/sanitation of oximeter and maintenance/storage of catheter bags, tubing and oxygen tubing. DON or designee will bring audits to QAPI meeting for review and to determine if audits should continue or be resolved. QAPI meets monthly.</p>		

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F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure infection control technique was maintained for: *One of one sampled resident (65) who was on transmission-based precautions by one of one certified nursing assistant (CNA) (I) and one of one licensed practical nurse (LPN) (G) during a straight catheterization procedure. *One of one unlicensed assistant personnel (UAP) (E) during the use of an oximeter for one of one sampled resident (71). *Keeping a catheter bag and tubing and oxygen tubing off of the floor for one of one sampled resident (60) by one of one CNA (I) and one of one unlicensed assistive personnel (UAP) (P). Findings include: 1. Observation on 8/10/21 at 2:13 p.m. of LPN G and CNA I performing a straight catheterization procedure for resident 65 revealed: *Unit coordinator/licensed practical nurse (LPN) H was also in the room. *CNA I was at the bed side to assist with the procedure. *LPN G had assisted resident 65 to try and void into a urinal. *Removed her gloves, did not perform hand hygiene. *She was putting on a pair of sterile gloves when unit coordinator/LPN H told her to stop and go wash her hands. *After she washed her hands she put on a new	F 880			

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F 880	<p>Continued From page 13</p> <p>pair of sterile gloves. *After the procedure, LPN G removed her gloves, performed hand hygiene, and put on a pair of gloves from her uniform top pocket. *After CNA I performed peri care he changed his gloves without performing hand hygiene.</p> <p>Interview on 8/10/21 at 2:34 p.m. with LPN G and CNA I regarding the above observation of lack of hand hygiene with the removal of gloves and taking gloves from a uniform pocket revealed: *They had both agreed they should perform hand hygiene when they remove their gloves. *LPN G agreed her pocket was not clean and she should not have kept extra gloves in her pockets.</p> <p>Interview on 8/10/21 at 2:34 p.m. with director of nursing (DON) B revealed she had agreed: *All staff should perform hand hygiene after removing gloves. *Staff should not keep extra gloves in their pockets.</p> <p>Review of the provider's 2018 Handwashing/Hand Hygiene/Non-Sterile Glove Use policy revealed: **6. Hand hygiene is the final step after removing and disposing of personal protective equipment." *When applying gloves they should be removed from the dispensing box one at a time.</p> <p>2. Observation on 8/11/21 at 8:06 a.m. of UAP E administering medications and taking resident 71's oxygen saturation revealed she: *Had taken an oximeter out of her pocket and taken resident 71's oxygen saturation. *Put the oximeter back into her pocket and walked back to the medication cart. *Removed the oximeter from her pocket,</p>	F 880			

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F 880	<p>Continued From page 14</p> <p>disinfected it, and set it on top of the medication cart.</p> <p>Interview on 8/11/21 at 8:20 a.m. with UAP E about the above observation revealed: *The oximeter would have been contaminated after she used it and should not have been put back in her pocket. *Her pocket was not clean. *She should not have kept the oximeter in her pocket.</p> <p>Review of the provider's revised July 2014 Cleaning and Disinfection of Resident-Care Items and Equipment revealed: **d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). *It did not address the storage of equipment.</p> <p>3. Observation on 8/10/21 at 9:23 a.m. of resident 60 sitting in his wheelchair in his room revealed: *Part of his catheter tubing was touching the floor. *The oxygen tubing hooked to the oxygen concentrator was lying on the floor touching his catheter tubing.</p> <p>Observation on 8/10/21 at 9:26 a.m. with CNA I and UAP P assisting resident 60 into the bed with a Hoyer lift revealed: *CNA I picked up the oxygen tubing and attempted to set it on the bedside table where it fell to the floor and remained there until it was placed back on the resident. *CNA I removed the catheter bag from the dignity bag below the wheelchair and set it on the floor while he removed the foot pedals and prepared the resident for transfer into the bed.</p>	F 880			

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F 880	<p>Continued From page 15</p> <p>Interview on 8/10/21 at 9:36 a.m. with UAP P regarding the above observation revealed: *It was not common practice for oxygen tubing to be on the floor, staff tried to drape it on the table or the oxygen concentrator. *She agreed the catheter tubing and bag should also, be kept off the floor.</p> <p>Interview on 8/10/21 at 9:38 a.m. with CNA I revealed: *He was not aware the oxygen tubing had been on the floor. *He had not realized he had set the catheter bag on the floor while providing care to resident 60. *Agreed the oxygen tubing and catheter tubing should not have been on the floor.</p> <p>Review of the provider's April 2016 Catheter Care: Indwelling Catheter policy revealed: "14. Check that tubing is not looped, kinked, clamped or positioned above the level of the bladder and off of the floor - place bag in catheter bag holder if appropriate."</p> <p>Review of the provider's updated July 2017 Oxygen Administration policy revealed: **Completion of procedure: -When oxygen is not in use, store oxygen tubing and cannula or mask in separate, labeled plastic bag."</p>	F 880			

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E 000	Initial Comments Surveyor: 29354 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 8/9/21 through 8/12/21. Prairie Heights Healthcare was found not in compliance with the following requirements: E001.	E 000	Aberdeen Plan Of Correction for Emergency Preparedness Survey of 8/12/21 The statements on this plan of correction are not admittance to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.	
E 001	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001	E001 1) IDT met to review and revise current Emergency preparedness plan to include: <ul style="list-style-type: none"> • Patient/client population, including, but not limited to persons at risk; type of services the facility had the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. • A system to track the location of on-duty staff in the facility during an emergency. • Policies and procedures for: sheltering in place for residents, staff, and volunteers who remained at the facility. • Procedures to preserve the patient information, protects confidentiality of patient information and secures and maintains the availability of records. • Developed a communication plan 	9/8/21

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

TITLE

(X6) DATE

Darcy Albrecht

Administrator

9/2/21

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.

SEP 09 2021

SD DOH-01C

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E 001	<p>Continued From page 1</p> <p>local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 43844</p> <p>Based on interview and record review, the provider failed to establish a complete emergency preparedness program (policies, procedures, communication plan, and contact information). Findings include:</p> <p>1. Interview on 8/11/21 at 11:00 a.m. and review of the provider's emergency preparedness program documentation with administrator A revealed:</p> <p>*They did not have a complete emergency preparedness program.</p> <p>*They had not:</p> <p>-Addressed patient/client population, including, but not limited to persons at risk; type of services the facility had the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.</p> <p>-Developed a system to track the location of</p>	E 001	<p>that includes the names and contact information for resident physicians and volunteers, contact information for the state licensing and certification agency, and the office of the state long-term care ombudsman, and a method to provide information about the facility's occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee.</p> <p>2)Audits will be completed by Administrator or designee as needed or identified.</p> <p>2) Administrator will take Emergency Preparedness Plan to monthly QAPI meeting for review/recommendations/ approval on 9/8/21 and on an annual basis.</p>	

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E 001	Continued From page 2 on-duty staff in the facility during an emergency. -Addressed policies and procedures for: --Sheltering in place for residents, staff, and volunteers who remained in the facility. --Medical documentation that preserves patient information, protects confidentiality of patient information and secures and maintains availability of records. -Developed a communication plan that had included: --Names and contact information for resident physicians and volunteers. --Contact information for the state licensing and certification agency, and the office of the state long-term care ombudsman. --A method to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee. *They had been aware of the requirements for a complete emergency preparedness program and had not included all of the requirements.	E 001			

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NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/11/21. Prairie Heights Healthcare (main building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		

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

TITLE

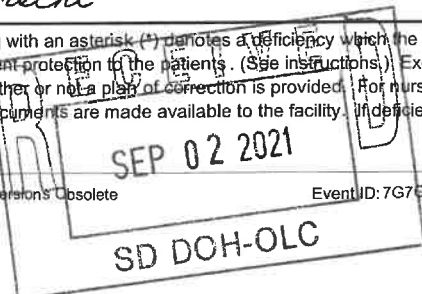
(X6) DATE

Darcy Albrecht

Administrator

9/2/21

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/11/21. Prairie Heights Healthcare (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000			

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

Darcy Albrecht

TITLE

Administrator

(X6) DATE

9/2/21

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SEP 02 2021

SD DOH-OLC

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2021
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NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/9/12 through 8/12/21. Prairie Heights Healthcare was found not in compliance with the following requirements: S206 and S210.</p>	S 000	<p>Aberdeen Plan Of Correction for Administrative Rules Survey of 8/12/21</p> <p>The statements on this plan of correction are not admittance to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.</p>	
S 206	<p>44:73:04:05 Personnel Training</p> <p>The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects:</p> <ul style="list-style-type: none"> (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. <p>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.</p>	S 206	<p style="text-align: center;">S206</p> <p>1)Employees K,L,M & N were educated by the Admin, DON, or designee on the SD reportable incidences and diseases, and the facility mandatory reporting process by 9/3/21.</p> <p>2)IDT reviewed/revised current orientation materials, processes, listing of SD reportable diseases and incidences, and the reporting process on 8/27/21.</p> <p>3)All employees have the potential of not being provided with mandatory reportable diseases and incidents and how the facility mandatory reporting process works. All staff will be educated on the same by Human Resource or Designee by 9/8/21.</p> <p>4)All new staff will be educated by Human Resource or designee on the SD reportable diseases and incidences and the facilities reporting process during orientation. In addition, a list of SD reportable disease and incidences and the facilities reporting process will become part of the annual training for staff.</p> <p>5)Human Resource will audit 2 employee files per week/8 weeks for compliance with the education on the SD reportable diseases and incidences and the facility reporting process. Human Resource will bring weekly audits to monthly QAPI meeting.</p> <p>6)QAPI meets monthly. Audits will be brought to the meeting for review by the QAPI team. At this time a decision will be made for the audits to either continue or to be resolved.</p>	9/8/21

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

Darcy Albrecht

TITLE

Administrator

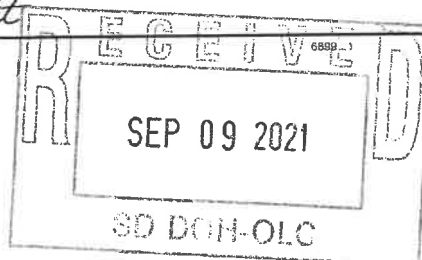
(X6) DATE

9/2/21

STATE FORM

B2WW11

If continuation sheet 1 of 5



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2021
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NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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(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) COMPLETE DATE
S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on record review, interview, and attempted policy review, the provider failed to ensure five of five sampled employees (K, L, M, N, and O) in orientation had received training about what incidents and diseases required mandatory reporting and how the process worked in the facility. Findings include:</p> <p>1. Review of employees K, L, M, N, and O's personnel files revealed: *The employees had been hired on the following dates: -10/16/20: Registered nurse M. -1/20/21: Occupational therapy assistant N. -2/11/21: Housekeeping aide K. -5/21/21: Dietary aide O. -5/25/21: Certified nursing assistant L. *There had been no orientation training regarding: -What incidents and diseases required mandatory reporting. -How the mandatory reporting process worked in the facility.</p> <p>Interview on 8/11/21 at 4:15 p.m. with human resource director R revealed she: *Was responsible for training new employees during their orientation. *Provided a list of orientation topics provided which did not list the training noted above. *Was unable to locate documentation for any of the above employees they had received the training noted above.</p>	S 206		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2021
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NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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S 206	Continued From page 2 Interview on 8/12/21 at 11:00 a.m. with administrator A regarding the above training revealed it had not been completed. On 8/11/21 at 4:45 p.m. the surveyor requested from director of nursing B the policy on employee orientation and annual training. No policy on employee orientation and annual training was received from the provider by the end of survey on 8/12/21.	S 206		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on record review, interview, and attempted policy review, the provider failed to ensure five of	S 210	S210 1)Employees K,L,M,N, & O health evaluations were completed, reviewed, and signed by health care professional on 8/12/21. 2)IDT reviewed/revised current process of the reviewing/signing of the employee health evaluations on 8/12/21. 3)Human Resources was educated by the Director of Nursing on the expectation to provide health form to Director of Nursing or designee within 14 days of hire for review and signature. Completed on 8/13/21. 4)All current employees have the potential of having an incomplete health evaluation in their files. An audit of all current employee files was completed by Human Resources on 8/16/21 to ensure completeness. 5)Human Resource will implement the completion and review of the employee health evaluation on checklist for orientation. 6)Human Resource will audit 2 employee files a week for 8 weeks for signature by health care professional. HR will bring weekly audits to monthly QAPI.	9/8/21

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2021
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NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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S 210	<p>Continued From page 3</p> <p>five sampled employees (K, L, M, N, and O) had a health evaluation that included a review for communicable diseases by a licensed health professional completed within fourteen days of being hired. Findings include:</p> <p>1. Review of the following sampled employees' K, L, M, N, and O's personnel files revealed: *The employees had been hired on the following dates: -10/16/20: Registered nurse M. -1/20/21: Occupational therapy assistant N. -2/11/21: Housekeeping aide K. -5/21/21: Dietary aide O. -5/25/21: Certified nursing assistant L. *The above employees' personnel files had no evidence of a signed health evaluation by a health care professional to determine they were free of communicable diseases.</p> <p>Interview on 8/11/21 at 4:15 p.m. with human resource director R regarding the above personnel files revealed she: *Was responsible for training new employees during their orientation. *Provided the "Employee's Medical History" form to the new employees on orientation day which included a space for: -Employee signature and date. -Director of nursing (DON)/assistant director of nursing signature and date. *Had the employee's sign the above form where indicated. *Had not forwarded the forms to the DON for review and signature.</p> <p>Interview on 8/11/21 at 4:45 p.m. with DON B confirmed she was responsible to review and sign the "Employee's Medical History" form certifying the employee was free of communicable</p>	S 210	QAPI meets monthly. Audits will be brought to meeting for review by the QAPI team. At this time a decision will be made for the audits to either continue or to be resolved.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2021
NAME OF PROVIDER OR SUPPLIER PRAIRIE HEIGHTS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401		
(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) COMPLETE DATE
S 210	Continued From page 4 diseases. On 8/11/21 at 4:45 p.m. the surveyor requested from DON B a policy about the "Employee Medical History" form and the process for its use. No policy was received from the provider by the end of survey on 8/12/21.	S 210		
S 000	Compliance/Noncompliance Statement Surveyor: 29354 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 8/9/21 through 8/12/21. Prairie Heights Healthcare was found in compliance.	S 000		

