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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/19/24 through 11/20/24. Platte Care Center was found not in compliance with the following requirements: F732 and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/19/24 through 11/20/24. Areas surveyed included resident safety related to a resident who left the facility without staff knowledge and resident neglect related to a staff member not following a resident's care plan related to the use of a mechanical lift. Platte Care Center was found to have past noncompliance at F600.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cordell Muilenburg (signature) — TITLE: administrator — (X6) DATE: 12-11-24

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 600	Continued From page 1 Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, record review, and policy review, the provider failed to protect one of one sampled resident (11) from abuse by one of one agency certified nursing assistant (CNA) (F) who insinuated she was videoing the resident when providing her care. This citation is considered past non-compliance based on review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's submitted SD DOH FRI regarding resident 11's incident revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated her cognition was intact. *On 7/9/24 at 9:00 p.m. she reported to licensed practical nurse (LPN) K that CNA F had been recording her while helping her with her bathroom care needs. *LPN K questioned CNA F who told her that she was not actually recording, but she had wanted resident 11 to believe she was. *LPN K reported the incident to administrator A. *CNA F was assigned to a different hallway for the rest of the night and monitored. *Interventions following their investigation of this incident included: -CNA F was terminated. -All residents received education regarding how to report abuse allegations. -Residents with a BIMS score of 8-15 were interviewed for signs or suspicions of abuse by staff. -Resident 11 was offered mental health services. -All staff were to receive education regarding abuse and how to report it.	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 600	Continued From page 2	F 600		

2. Interview on 11/20/24 at 11:10 a.m. with CNA D revealed:
*They had received education on abuse in their huddles and online.
*She knew how to report abuse to the designated people which included administrator A and director of nursing (DON) B.
*She knew how to identify signs and symptoms of resident abuse.

3. Interview on 11/20/24 at 11:14 a.m. with resident 11 in her room revealed:
*She had issues with CNA F prior to the video recording incident, but she never reported anything.
*She had been offered mental health services, but she declined because she didn't think it was necessary.

4. Interview on 11/20/24 at 2:28 p.m. with administrator A revealed:
*CNA F had a background check that indicated no prior abuse allegations when hired.
*CNA F had completed education on abuse prior to being hired and completed the facility's education on abuse during her orientation.
*He had contacted her agency and reported the incident.
*Law enforcement had been notified of the incident.

The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/20/24 after record and policy review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding abuse and how to report it, resident education and interviews had

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 600	Continued From page 3 been completed, and interviews revealed staff understood the education provided regarding those topics. Based on the above information, non-compliance at F600 occurred on 7/9/24, and based on the provider's 7/12/24 implemented corrective action for the deficient practice confirmed on 11/20/24, the non-compliance is considered past non-compliance.	F 600		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732	The Administrator acknowledges that the facility failed to post daily staffing data regarding actual hours and place in a prominent place accessible to residents and visitors. Administrator made changes to the staffing data to accurately reflect scheduled and actual staffing data for RN's, LPN's, and CNA's and will be posted in a prominent place accessible to residents and visitors effective 12/11/2024. Administrator will monitor that staffing data and changes are continually updated daily and will review all of the daily staffing sheets monthly to ensure that data is accurate and posted. This review and data will be added to quality dashboard which will be showed and reviewed at regularly scheduled QAPI meetings and QA meetings which are scheduled at minimum quarterly.	12/11/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 732	Continued From page 4 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure the posted daily staff data reflected the actual hours worked by certified nursing assistants (CNAs). Findings include: 1. Observation on 11/20/24 at 1:13 p.m. revealed: *The facility's staff hours posting form was located in the front entrance hallway on a bulletin board. -The form included the facility name, date, resident census, and hours scheduled for licensed nurses and certified nurse aides. --The hours scheduled were pre-printed on a computerized form. Interview on 11/20/24 at 1:15 p.m. with CNA E, director of nursing B, and administrator A, regarding the posting of staff hours revealed: *CNA E and another staff person were responsible for posting the staff hours. *The CNA area of the form used to post staffing hours did not include actual hours worked. *The form that was posted included only hours scheduled and was not updated to include any changes in CNA hours worked. *They stated the scheduled licensed nurse hours	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 732	Continued From page 5 were always accurate to actual hours worked. *They confirmed they were not aware the staff hours posted should be actual hours worked.	F 732		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure the dishwasher temperatures were monitored, recorded, and interventions were documented for temperatures out of range for one of one dishwasher used for the cleaning and sanitization of dishes and items used to prepare and serve residents' food. Findings include: 1. Observation on 11/19/24 at 11:30 a.m. of cook H revealed:	F 812	The Administrator and Dietary Manager acknowledge that the facility failed to ensure that dishwasher temperatures were monitored, recorded, and interventions were documented for temperature out of range for the dishwasher used to clean and sanitize dishes and items to prepare and serve resident's food. Directed in-service training will be completed with dietary staff before 12/18/2024. An intervention log was created on 12/11/2024 and was placed with the dishwasher monitoring log to record temperatures out of range, as well as the interventions taken to ensure that the dishwasher temperatures are reaching the manufacturers recommendations for cleaning and sanitizing. On 12/11/2024 a job duties checklist was created to ensure that dishwasher staff are not forgetting to document dishwasher temperatures at least once per day per policy. The Dietary Manager will monitor that dishwasher temperatures are being completed once per day per policy. This will be reviewed using the log sheet and inputted monthly onto the departments quality dashboard that will be shared and reviewed at regularly scheduled QAPI meeting and QA Meeting which occurs at least quarterly. The Dietary Manager will in addition, review the new intervention log and compare with the dishwasher temp log to make sure that any inadequate temperatures have an intervention that resulted in the temperature being fixed. This will be reviewed and inputted monthly onto the departments quality dashboard that will be shared and reviewed at regularly scheduled QAPI meeting and QA Meeting which occurs at least quarterly.	12/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 812	Continued From page 6	F 812		

*She removed the plates from the serving stack and placed them in the dishwasher.
*After the dishwashing cycle was completed, she returned the plates to the serving stack.
*She then served the lunch meal on the plates that she had washed.

2. Review of the provider's "Dishwasher Temperature Record" revealed:
*The dishwasher was a high-temperature dishwasher.
*The "Dishwasher Temperature Record" had areas for documentation of the "Wash Cycle Temp" and the "Rinse Cycle" temperatures.
*There were areas for documentation labeled "B [breakfast]", "L [lunch]", and "D [dinner]" for each date.
*There were grayed-out areas on the temperature log that coincided with the bottom of the form indicated that the temperatures were in degrees Fahrenheit (F) and that the "Wash Temps needed to be [between] 150-165 [degrees F]" and "Final Rinse Temps need to be 180 [degrees F] or> [greater]".
*There was an area on the form that indicated, "If not in appropriate range, put date here and what was done to fix the issue:".
*There were multiple areas on the form where there were no documented temperatures.
*There was documentation of the "Wash Cycle Temp" being out of range.
-On 11/3 the dinner temperature was documented as 148 degrees F.
-On 11/10 the lunch temperature was documented as 149 degrees F.
-On 11/13 the dinner temperature was documented as 149 degrees F.
*There was no documentation in the interventions temperatures that were out of range.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 812	Continued From page 7	F 812		

3. Record review on 11/20/24 of the provider's 2024 September, October, and November dishwasher temperature logs revealed:
*The September log indicated there were:
-Eighteen missed opportunities for temperature documentation.
-Three days that had no temperature documentation for all three mealtimes (9/11, 9/12, 9/22).
-Five times when the wash cycle temperature was documented as having been out of range.
-Thirteen times when the rinse cycle temperature was documented as having been out of range.
-No documented interventions for when those temperatures were out of range.
*The October log indicated there were:
-Thirty-four missed opportunities for temperature documentation.
-Two days had no temperature documentation for all three mealtimes (10/30 and 10/31).
-One time when the wash cycle temperature was documented out of range.
-Seven times when the rinse cycle temperature was documented out of range.
-No documented interventions for when those temperatures were out of range.
*November's log indicated there were:
-Eighteen missed opportunities for temperature documentation.
-Two days had no temperature documentation for all three mealtimes (11/1 and 11/2).
-Three times when the wash cycle temperature was documented out of range.
-No documented interventions for when those temperatures were out of range.

4. Interview on 11/20/24 at 10:03 a.m. with dishwasher I regarding the dishwasher

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 812	Continued From page 8	F 812		

temperatures indicated:
*Temperatures were to be recorded after every meal.
*The temperatures were read from a digital display that indicated if it was a wash or rinse cycle and the temperature.
*She recorded the temperatures from the last wash cycle of each meal service on the "Dishwasher Temperature Form".
*She identified the gray areas on the form indicated the acceptable range for the wash and rinse temperatures.
*She stated if the temperatures were out of range, she would notify her supervisor.

5. Interview on 11/20/24 at 11:10 a.m. with dietary manager G regarding the high-temperature dishwasher revealed:
*She had been in her position for one month.
*She would expect the dishwasher temperature to be read and documented by staff twice daily.
*She had not reviewed the dishwasher policy or the dishwasher temperature documentation.
*If the dishwasher temperature was out of range, she would expect staff to notify maintenance and she would notify administrator A.
*She stated that she would expect that staff would not continue to wash dishes if the dishwasher temperature was not in the appropriate range.

6. Interview on 11/20/24 at 11:52 a.m. with administrator A regarding the high-temperature dishwasher revealed:
*He expected the temperatures would be checked by staff three times daily with meals.
*He agreed the temperatures were not being taken as often as he expected and there was no documentation of interventions for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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 812	Continued From page 9 out-of-range temperatures. *He indicated the temperatures in the kitchen were being followed in QAPI (quality assurance and performance improvement) and there was a PIP (performance improvement plan) that had been developed but had not been implemented. *He expected staff to notify maintenance if the temperatures were out of range. *Maintenance verified the accuracy of the gauges on the high-temperature dishwasher monthly. 7. Review of the provider's 10/2024 Sanitation, Safety, Equipment---Machine Dishwashing policy revealed that "Temperature/appropriate sanitation levels are checked & recorded daily."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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
K 000	INITIAL COMMENTS A recertification survey was conducted on 11/20/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Platte Care Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (announcement and closing of doors). Findings include: 1. Observation at 1:15 p.m. on 11/20/24 revealed the staff member responding to the simulated fire in the kitchen was not fully aware of the facility's	K 712	The Director of Facility Services acknowledges that Platte Care Center Avera failed the fire drill on 11/20/2024 because kitchen staff were not fully aware of facility fire drill procedures. To achieve compliance, a staff in-service was held on 12/5/2024 in the dietary department for fire drill procedures and to explain the importance of knowing what to do in case of a fire to protect the facility, staff, visitors, and residents. The policy will be assigned to dietary employees for staff to review and complete before 12/18/2024 and at least quarterly until the next survey. The Dietary Manager will ensure that all dietary staff have completed their assigned fire drill policy. Records of the completions and the in-service training that were completed will remain with the Director of Facility Services. The Dietary Manager will continue to monitor and assign the policy quarterly to dietary staff until the next survey. The results of the number of staff who have successfully completed the assignment will be reported to QAPI meeting which will be located on the dietary departments quality dashboard which will also be submitted and shared at QA meeting which is quarterly.	12/5/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cordell Mutenberg | TITLE: administrator | (X6) DATE: 12-11-24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____________	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	**609 EAST 7TH** **PLATTE, SD 57369**

(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
K 712	Continued From page 1 fire drill procedures. During the process of responding to the simulated fire, the kitchen staff member involved specifically had to be instructed step-by-step on what actions to take. Specifically, the director of plant operations had to instruct the responding staff person to "go to the nurse station so they can announce it" he also had to instruct the responding staff person to close all doors to the corridor from the affected space. Interview with the director of plant operations at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 712		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING ______ B. WING ______	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH PLATTE, SD 57369

(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
E 000	Initial Comments 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 on 11/20/24 Platte Care Center was found not in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cordell Mertenberg	administrator	12-11-24

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.

PRINTED: 12/03/2024
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10664	A. BUILDING: ____ B. WING ____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	**601 E 7TH POST OFFICE BOX 200** **PLATTE, SD 57369**

(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 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/19/24 through 11/20/24. Platte Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Codell Muilenburg
TITLE: administrator
(X6) DATE: 12-11-24