STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW , ABERDEEN, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/29/25 through 7/31/25. Prairie Heights Healthcare was found not in compliance with the following requirement: F851.	F0000	Aberdeen Plan of Correction for Recertification Health Survey 7/31/25 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.	8/5/25
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i).The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);	F0851	F851 1) Payroll Based Journal (PBJ) data for Federal Fiscal Quarter 2 can no longer be submitted. 2) Corporate team, Administrator and Accounting Clerk did review and revise the process for PBJ Preparation and Submission Schedule on 7/29/25. 3) PBJ data for Fiscal Quarter 3 was reviewed by accounting clerk with the contracted submission company (Votive) on 7/31/25. 4) PBJ data for Fiscal Quarter 3 was submitted by Votive to Centers for Medicare & Medicaid Services on 8/5/25 and accepted as per validation report received by administrator. 5) The administrator will audit PBJ submission timeliness quarterly for one year. 6) The administrator will take the results of these audits to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for review and further recommendations.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darcy Albrecht	Administrator	8/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW , ABERDEEN, South Dakota, 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
F0851 SS = F	Continued from page 1 (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll Based Journal (PBJ) CASPER (Certification and Survey Provider Enhanced Reporting) reports, interview, and record review, the provider failed to ensure the PBJ data was submitted accurately to the Centers for Medicaid and Medicare Services (CMS) for Federal Fiscal Quarter 2 (January, February, and March 2025). Findings include: 1. Interview on 7/29/25 at 4:20 p.m. with administrator A regarding Fiscal Year 2025 Second Quarter (Q2) PBJ data revealed that the data was submitted to the contracted submission company, and there had been an error, but she did not recall what the error was. Follow-up interview on 7/29/25 at 4:59 p.m. with administrator A regarding Fiscal Year 2025 Q2 PBJ data submission confirmed the data submission had not been accepted by CMS due to an error. She indicated that accounting clerk B would be able to provide additional information.	F0851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW , ABERDEEN, South Dakota, 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
F0851 SS = F	Continued from page 2 Interview on 7/31/25 at 10:28 a.m. with accounting clerk M regarding PBJ data submission revealed she was not aware that the Q2 data for the Federal Fiscal Year 2025 submission to CMS had not been accepted by CMS. Review of the provider's undated PBJ Preparation and Submission Schedule instructions revealed: **"PBJ submission due 11:59pm [p.m.] EST [Eastern Standard Time] on the 45th calendar day following the end of the reporting quarter to be considered timely." *The Q2, submission due date was May 15, and was to be submitted in the first week of May to CMS. *Validation Reports were to be provided to the provider by the contracted submission company and were to be reviewed during the second business week of the submission month (at a minimum of 72 hours) before the CMS deadline.	F0851		

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
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 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 from 7/29/25 through 7/31/25. Prairie Heights Healthcare was found in compliance.	S 000	Aberdeen Plan of Correction for Administrative Rules Survey 7/31/25 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.	
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on from 7/29/25 through 7/31/25. Prairie Heights Healthcare was found not in compliance with the following requirements: S206, S236, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (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	S 206	S 206 1) Staff members D,E,F,& L will complete the required training by 8/29/25. 2) A facility-wide audit of all personnel training records will be completed by human resources to identify staff that need to complete training on accident prevention safety procedures, dining assistance/nutritional risks and hydration, and advance directives by 8/22/25. 3) Personnel identified in the audit will complete the needed training on accident prevention safety procedures, dining assistance/nutritional risks and hydration, and advance directives by 9/5/25 4) Accident prevention safety procedures, dining assistance/nutritional risks and hydration, and advance directives	9/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darcy Albrecht — TITLE: Administrator — (X6) DATE: 8/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 206	Continued From page 1 hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review and interview, the provider failed to ensure training was completed on the required topics for: *Advance directives for three of five sampled employees (E, F, and L) within 30 days of hire and annually. *Dining assistance, nutritional risks, and hydration, for two of five sampled employees (D and L) within 30 days of hire and annually. *Accident prevention safety procedures for one of five sampled employees (D). Findings include: 1. Review of registered nurse D's employee record revealed she: *Was hired on 1/8/24. *Had not completed the required annual training on: accident prevention safety procedures and dining assistance, nutritional risks, and hydration. 2. Review of certified nursing assistant (CNA) E's employee record revealed she: *Was hired on 1/9/25. *Had not completed the required orientation	S 206	were added to the training schedule for new hires and annually for necessary job titles on 8/13/25. 5) Human Resource or Designee will audit 3 employee files per week x 8 weeks starting 9/8/25 to ensure training on accident prevention safety procedures, dining assistance/nutritional risks and hydration, and advance directives has been completed within 30 days of hire and annually. 6) QAPI meets monthly. Human Resource Director will bring audits 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 206	Continued From page 2 training on advance directives within 30 days of hire. 3. Review of CNA F's employee record revealed she: *Was hired on 5/13/24. *Had not completed the required annual training on advance directives. 4. Review of housekeeper L's employee record revealed she: *Was hired on 2/17/25. *Had not completed the required orientation training on advanced directives, and dining assistance, nutritional risks, and hydration within 30 days of hire. 5. Interview on 7/31/25 at 11:35 a.m. with human resource director C regarding staff training revealed: *The state-required trainings were not included in the provider's current online training program. *The state-required trainings were completed at all staff meetings each month. *Not all employees attended the all-staff meetings each month. *There was no policy regarding staff training. *She confirmed the above employees had not completed training on all of the required topics. *She confirmed there was no documentation to support that the above employees had received all of the state-required training.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident	S 236	S236 1) Nursing staff will complete a 2-Step Mantoux test on residents 1 & 51 by 8/25/25.	9/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 236	Continued From page 3 shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *One of five sampled residents (1) had his second two-step Tuberculosis (an infectious disease that most often affects the lungs) (TB)	S 236	2) DON and Admin did meet to review and revise the policy regarding resident TB screening on 8/13/25. 3) DON or Designee will educate all professional nurses on the revised policy regarding resident TB screening by 8/22/25. 4) All current residents have the potential of not having a completed 2 Step Mantoux upon admission to the facility. DON or Designee will complete an audit by 8/15/25 of all current residents to ensure a 2 Step Mantoux was completed upon admission to the facility. 5) All current residents will have a completed 2 Step Mantoux test by 8/29/25. 6) DON or Designee will audit 3 random resident immunization records/week for 8 weeks to ensure they have completed a 2 Step Mantoux test within 21 days of admission. 7) 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 236	Continued From page 4	S 236		

skin test read within 48 to 72 hours after it was administered, to determine if he was a positive TB reactor.
*One of five sampled residents (2) had her first two-step TB skin test read within 48 to 72 hours after it was administered, to determine if she was a positive TB reactor.

Findings include:

1. Review of resident 1's medical record revealed:
*He was admitted on 5/12/25.
*He had received the second dose of his TB skin test on 5/25/25, and the results were documented as "pending".
-That was past the results reading range of 48 to 72 hours after administration of the test.

2. Review of resident 51's medical record revealed:
*She was admitted on 4/15/25.
*She received the first dose of her TB skin test on 4/15/24, and the results were documented as "pending".

3. Interview on 7/31/25 at 10:11 a.m. with director of nursing (DON) B revealed:
*The completion and reading of the residents' TB screening tests results was assigned to the charge nurse on duty and was to be documented in the medication administration record for that resident.
*She was not aware that the above TB screening skin test results had not been read.
*She indicated they may have been read, but the results may not have been documented.

4. Review of the providers' 2024 TB Infection Control Plan policy revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 236	Continued From page 5 *"Residents and staff are tested for latent TB infection and screened for TB disease, if infected with TB. *The policy did not address how the residents and staff were tested for TB.	S 236		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review and interview, the provider failed to ensure: *Three of three sampled dietary employees (G, H, and I) had received ongoing training for the required topic of nutrition and hydration. *Two of two newly hired sampled dietary employees (J and K) had received initial training for the required topic of nutrition and hydration. Findings include: 1. Review of employee personnel records	S 301	S 301 1) Staff members H,I,J& K will complete the required training by 8/29/25. 2) Human resource will complete an audit of all dietary personnel to ensure the staff have completed training on nutrition and hydration by 8/22/25. 3) Personnel identified in the audit will complete the needed training on nutrition and hydration 9/5/25 4) Nutrition and hydration training were added to the training schedule of dietary personnel for new hires and annually on 8/13/25. 5) Human Resource or Designee will audit 1 dietary employee file per week x 8 weeks starting 9/8/25 to ensure training on nutrition and hydration has been completed within 30 days of hire and annually. 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	9/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10588	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 301	Continued From page 6 revealed: *Dietary cook H was hired on 3/5/08, dietary cook G was hired on 4/4/22, and dietary cook I was hired on 6/3/24. *There was no documentation to support that those three cooks had received the required ongoing training for the topic of nutrition and hydration. 2. Review of employee personnel records revealed that dietary aide J was hired on 3/20/25, and dietary aide K was hired on 4/3/25. *There was no documentation to support that those dietary aides had completed the required initial training on the topic of nutrition and hydration. 3. Interview on 7/29/25 at 4:56 p.m. with administrator A revealed the provider did not have a policy regarding staff education. 4. Interview on 7/31/25 at 11:35 a.m. with human resource director C regarding staff training revealed: *The annual training for dietary employees was to be completed each year with the annual review of their job performance. *The initial training for dietary employees was to be completed when they were hired. *The state-required training on nutrition and hydration for dietary employees was not included in the provider's current training program. *She confirmed the five above dietary employees had not completed the required training on the topic of nutrition and hydration.	S 301		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING B. WING	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW , ABERDEEN, South Dakota, 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
E0000	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 on 7/31/25. Prairie Heights Healthcare was found in compliance.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darcy Albrecht	Administrator	8/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW , ABERDEEN, South Dakota, 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
K0000	INITIAL COMMENTS A recertification survey was conducted on 7/31/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Prairie Heights Healthcare Building 2 was found in compliance.	K0000		
K0000	INITIAL COMMENTS A recertification survey was conducted on 7/31/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Prairie Heights Healthcare Building 1 was found in compliance.	K0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darcy Albracht	Administrator	8/13/25