DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/04/2024 FORM APPROVED

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	ECONSTRUCTION		PLETED
		435004	B. WING		1	C /24/2024
	ROVIDER OR SUPPLIER		.	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 658 SS=E	CFR Part 483, Subpaterm Care facilities with 10/22/24 through 10/2 included Nursing Ser Resident/Patient/Clie not protected. Prairie found not in complian requirement(s): F658 Services Provided McCFR(s): 483.21(b)(3) Compater CFR(s): 483.21(b)(3)	arvey for compliance with 42 art B, requirements for Long vas conducted from 24/24. Areas surveyed vices, Infection Control, int Rights, Resident's Privacy Heights Healthcare was see with the following, F760 are Plans dor arranged by the facility, imprehensive Care Plans dor arranged by the facility, imprehensive care plan, astandards of quality. To is not met as evidenced Dakota Department of inplaint report, interview, ovider failed to ensure four of four sampled in not meet professional DON) (B) who did not follow on administration mor the lin administration when to resident 1. document a wound ne of completion or identify it it was documented in	F 658	Aberdeen Plan of Correction for Cor Survey of 10/24/24. The statements on this plan of correct admittance to and do not constitute a agreement with the alleged deficient To remain in compliance with all feet state regulations, the center has taken as set forth in the following plan of of	tion are not n ies herein. eral and or will act orrection. center's deficiencies indicated. Nursing nd (*) met to the inistration, mentation at the oensure	200

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 ays 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.

FORM CMS-2567(02-99) Previous Vei

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Event ID: QG0U11

Facility ID: 0033

if continuation sheet Page 1 of 8

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE	SURVEY LETED
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		435004	B. WING			10/	24/2024
	ROVIDER OR SUPPLIER HEIGHTS HEALTHCARE			40	REET ADDRESS, CITY, STATE, ZIP CODE 00 8TH AVENUE NW BERDEEN, SD 57401		
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F 658	director of nursing (D *She confirmed she n regarding resident 1's p.m. *She confirmed reside administered 62 units insulin) insulin, he ins Humalog (fast-acting) 2. Review of the prov report dated 7/6/24 at *The report confirmed units of Humalog insuluits of Lantus insulin *The report indicated error was "Both Lantus stored in the same batabel." *The report indicated Lantus insulin pen to remaining 7 units of re she realized that the id different colors, and in error had occurred. *The report indicated called, the Lantus ins resident was given a *The report indicated taken to the hospital.	23/24 at 3:30 p.m. with ON) B revealed: nade the medication error is insulin on 7/6/24 at 9:00 ent 1 should have been is of Lantus (long-acting tead received 55 units of) insulin. ider's medication error it 9:00 p.m. revealed: did that resident 1 received 55 ulin instead of the ordered 62 in. a contributing factor to the is and Humalog pens were aggie in the cart with one when DON B got a new prepare to administer the esident 1's Lantus insulin, insulin pens were two dentified the medication the on-call provider was ulin dose was held, and the snack. that the resident was not	F	658	2) Administrator did review with DON the policies on medicatio administration, insulin administration, & documentatio guidelines including the acknowledgement of late entrie to ensure the following are followed: rights of medication administration, proper insulin administration and late entry documentation on 11/5/24. 3) DON did review with employe D the certified medication aide description to ensure they rema within their unlicensed but cert skill set; including inability to a pain and/or psychotropic medicassessments on 11/6/24. 4) All diabetics have the potential receiving the incorrect dose/typ insulin. DON or designee will reducate all licensed nurses on t policy of medication and insuli administration to ensure the Fir Rights of Medication Administ are followed by 11/15/24.	es C & job in ified complete cation of pe of re-he in ve	
		ted on insulin use and that					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
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1		435004	B. WING			1	24/2024	
PRAIRI	PROVIDER OR SUPPLIER E HEIGHTS HEALTHCARE			40	TREET ADDRESS, CITY, STATE, ZIP CODE DO 8TH AVENUE NW BERDEEN, SD 57401			
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F 65	current blood sugar is orders: Check blood next 4 hours, 10 p.m. a.m. Do not give Lan provider again in the sugar results to see it given. Pt [patient] aw updated on orders." *On 7/6/24 at 10 p.m was 143 milligrams p *On 7/6/24 at 11 p.m was 115 mg/dl. *On 7/7/24 at 12 a.m was 123 mg/dl. *On 7/7/24 at 1 a.m., was 118 mg/dl. *Resident 1 was give physician. -He did not show any Review of the SD DO 10/4/24 revealed: *The complainant wis -Director of nursing (but had charted that assessment on resid from the hospital 9/2 -DON B was not in the resident returned from have performed that documented on. -Certified medication outside their scope of Surveyor 49238 4. Interview on 10/23 director of nursing (E *She had gone to a certified medication outside their scope of the s	s 215 with the following sugars every hour for the ., 11 p.m., 12 a.m., and 1 tus tonight. Call on call am with the a.m. blood f added Lantus should be are, Daughter [name] ., resident 1's blood glucose er deciliter (mg/dl), resident 1's blood glucose ., resident 1's blood glucose resident 1's blood glucose an snack as order by on-call or signs of hypoglycemia. DH complaint report dated shed to remain anonymous. DON) B was at a conference she completed a wound ent 4 when she returned 4/24. The building at the time that me the hospital and could not assessment she aides completed duties of practice.	F	658	5) All residents have the potential having documentation in their record that has not been reflect late entry when needed. DON designee will re-educate all lic nurses on the documentation gincluding acknowledgement of entries to ensure accurate documentation by 11/15/24. 6) All residents have the potential having a pain and/or a psycholomedication assessment complecertified medication aide (CM than a licensed nurse. DON or will re-educate all licensed nurse including the CMAs and licensed nurse including the CMAs inability complete pain and psychotrop medication assessments to ensure assessments are completed by licensed nurse by 11/15/24. 7) DON or designee will audit 3 insulin injections/week for 8 w starting 11/18/24 to ensure the dose/type of insulin is being administered.	medical ted as a or ensed uidelines f late I of tropic ted by a A) rather designee reses and usibilities to ic ture the a random veeks		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		TRUCTION		(X3) DATE SURVEY COMPLETED	
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PRAIRIE I	ROVIDER OR SUPPLIER			400 8TH	ADDRESS, CITY, STATE, ZIP CODE I AVENUE NW DEEN, SD 57401		24/2024	
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F 658	the nurse who had be see the resident hers. *She had to complete resident 2 who came a deep tissue injury o *She agreed she comfor that wound assess *She agreed she shot assessment as a "late *She stated she would Friday from 8:00 a.m. sometimes stay until \$\frac{1}{2}\text{remotely from home.}\$ 5. Review of medication (MARs) revealed: *Certified medication documented antipsycon 8/8/24 and 8/20/24 *She had documented resident 4 on 9/6/24. 6. Interview on 10/24/ revealed: *She stated she had reassess for psychotrop that treat psychotic coand hallucinations) medicality but had documented residents she was she charted yes or no behaviors. *She stated she asses level by resident's ver resident's facial expretheir pain level.	pital. of feel she could depend on en working and wanted to elf. a wound assessment for back from the hospital with in her heel. pleted the documentation ment the next day remotely. Id have charted the wound entry", but she did not. d work Monday through to 4:30 p.m. and 6:30 p.m. and con administration records aide (CMA) D had notic medication side effects for resident 3. d a pain assessment for 24 at 9:48 a.m. with CMA C not been trained on how to ic [brain altering medication anditions such as delusions edication side effects at this ented behavior information was familiar with. c answers for residents assed residents for their pain	F6	58	B) DON or designee will audit to week's documentation of 3 rates residents/week for 8 weeks start/18/24 to ensure any late entercorded as such. DON or designee will audit to week's pain and or psychotro medication assessment of 3 rates residents/week for 8 weeks start/18/24 to ensure the assessative to meeting for review by the QAPI meets monthly. DON of designee will bring audits to meeting for review by the QAAt this time a decision will be the audits to either continue or resolved.	ndom arting atries are ne prior oic undom arting nents are o r he PI team.		

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F 658	B regarding CMAs or psychotropic medicat *DON B admitted that documented pain and assessments, and shiftom CMA C after her surveyors. -She said CMA C ask have been charting the no. *DON B stated she will doing that and it was practice, but she had to see the normal section, insulin administration. *Preparation section, insulin, dosage requimethod of administration, insulin, dosage requimethod of administration, to assest the order on the med physician's order." 9. Review of the providescription dated Qtr *"Administering Medi Unlicensed Medication." 9. Review of the providescription dated Qtr *"Administering Medi Unlicensed Medications admost be delegated to upersonnel (Unlicense following;" -"6. Exercising of nur assessments which vintervention."	r higher. /24 at 11:40 a.m. with DON ompleting pain and ion assessments revealed: t two CMAs (C and D) had d psychotropic medication e had just heard about that r interview with the sed her today if she should nose things and DON B told as not aware they had been not in their scope of instructed them to stop. iders's September 2014 a policy revealed: number three, "The type of rements, strength, and ton must be verified before sure that it corresponds with ication sheet and the ider's medication aide job 2,2020 revealed: cations-Specific to on Aides." ministration tasks that may inlicensed assistive and Medication Aides) are the sing judgement,		358			
SS=D	residents are Free 0	a Significant Med Effors	F	760			

F 760 Continued From page 5 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, interviews, record review, and policy review, the provider failed to keep one of one resident (f) free from a significant medication error when administered an incorrect dose of insulin by director of nursing (B). Findings include: 1. Review of SD DOH 10/4/24 complaint report revealed: "DON B had a major medication error where she gave the incorrect insulin (large dose) to a resident but it was never reported or counted as a medication error." The complainant identified the resident in this incident as resident 1. 2. Interview on 10/22/24 at 2:40 p.m. with resident 1 revealed: "He had a Brief Interview for Mental Status (BIMS) score 8, which indicated he had moderate cognitive impairment. "He reported that the staff did a good job providing care for him. "He confirmed he was diabetic and required insulin injections. "He was unable to recall ever having any problems getting his insulin. 3. Interview on 10/23/24 at 9:55 a.m. with certified medication and instruction to expect the policy of insulin administration to ensure proper	OLIVILIV	OT OIT MEDIONITE OF	ILDIONID OLIVFIOLO				CIME IA	J. 0936-039 i
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PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (CACI DEFICIENCY MUST BE PRECEDED BY FILL TAGE) F 760 Continued From page 5 CFR(s): 483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, interviews, record review, and policy review, the provider failed to keep no ef one resident (1) free from a significant medication error when administered an incorrect dose of insulin plens in separate storage bags and to include the storage of insulin administration. The team also reviewed and revised the roles and responsibilities of the CMAs and licensed nurses to reflect who is responsible for insulin administration on 11/5/24. 1. Review of SD DOH 10/4/24 complaint report revealed: "DON B had a major medication error where she gave the incorrect insulin (large dose) to a resident but it was never reported or counted as a medication error." "The complainant identified the resident in this incident as resident 1. 2. Interview on 10/22/24 at 2:40 p.m. with resident 1 revealed: "He had a Brief Interview for Mental Status (BIMS) score 8, which indicated he had moderate cognitive impairment. "He reported that the staff did a good job providing care for him. "He confirmed he was diabetic and required insulin injections." "He was unable to recall ever having any problems getting his insulin. 3. Interview on 10/22/24 at 19:55 s.m. with certified medication aide (CMA) C revealed CMAs did not			435004	B. WING			10/	24/2024
F 760 Continued From page 5 CFR(s): 493.45(f)(2) The facility must ensure that its- §433.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, interviews, record review, and policy review, the provider failed to keep one of one resident (1) five from a significant medication error when administered an incorrect dose of insulin by director of nursing (8). Findings include: 1. Review of SD DOH 10/4/24 complaint report revealed: "DON B had a major medication error when administered an encident but it was never reported or counted as a medication error." "The complainant Identified the resident in this incident as resident 1. 2. Interview on 10/22/24 at 2.40 p.m. with resident 1 revealed: "He had a Brief Interview for Mental Status (BIMS) score 8, which indicated he had moderate cognitive impairment. "He reported that the staff did a good job providing care for him. "He was unable to recall ever having any problems getting his insulin. 3. Interview on 10/23/24 at 9.55 a.m. with certified medication of 10/23/24 at 9.55 a.m. with certified medication of the substitute of the audits to either continue or to be resolved.					44	00 8TH AVENUE NW		
F760 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, interviews, record review, and policy review, the provider failed to keep one of one resident (1) free from a significant medication error when administered an incorrect dose of insulon by director of nursing (B). Findings include: 1. Review of SD DOH 10/4/24 complaint report revealed: "DON B had a major medication error where she gave the incorrect insulin (large dose) to a resident but it was never reported or counted as a medication error." The complainant identified the resident in this incident as resident 1. 2. Interview on 10/22/24 at 2:40 p.m. with resident 1 revealed: "He had a Brief Interview for Mental Status (BIMS) score 8, which indicated he had moderate cognitive impairment. "He reported that the staff did a good job providing care for him. "He confirmed he was diabetic and required insulin injections. "He was unable to recall ever having any problems getting his insulin. 3. Interview on 10/23/24 at 9:55 a.m. with certified medication on 10/23/24 at 9:55 a.m. with certified medication in error to be include the storage of insulin pens in separate storage lags and to include the six rights of medication administration. The team also reviewed and revised the roles and responsibilities of the CMAs and licensed nurses to reflect who is responsible for insulin administration. The team also reviewed and revised the roles and responsible for insulin administration on 11/5/24. 3. All diabetics have the potential of receiving the incorrect dose/type of insulin administration to ensure reporter insulin administration to ensure the Five Rights of Medication administration on 11/5/24. 4. DoNo r designee will audit 3 random insulin injections/week for 8 weeks starting 11/18/24 to ensure the correct dose/type of finsulin is being administered. 5. QAPI meets monthly. DON or de	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
\$483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (\$D DOH) complaint online report, interviews, record review, and policy review, the provider failed to keep one of one resident (1) free from a significant medication error when administered an incorrect dose of insulon by director of nursing (B). Findings include: 1. Review of SD DOH 10/4/24 complaint report revealed: ""DON B had a major medication error where she gave the incorrect insulin (large dose) to a resident but it was never reported or counted as a medication error." "The complainant Identified the resident in this incident as resident 1. 2. Interview on 10/22/24 at 2:40 p.m. with resident 1 revealed: "He had a Brief Interview for Mental Status (BIMS) score 8, which indicated he had moderate cognitive impairment. "He confirmed he was diabetic and required insulin injections. "He was unable to recall ever having any problems getting his insulin. 3. Interview on 10/23/24 at 9:55 a.m. with certified medication aide (CMA) C revealed CMAs did not	F 760	o o minimus and to min page	5	F	760	F760		12/4/24
insulin injections. *He was unable to recall ever having any problems getting his insulin. 5. QAPI meets monthly. DON or designee 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 medication aide (CMA) C revealed CMAs did not resolved.		§483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on South Dak (SD DOH) complaint record review, and potable to keep one of cignificant medication incorrect dose of insu (B). Findings include: 1. Review of SD DOH revealed: "DON B had a major gave the incorrect insuresident but it was nemedication error." "The complainant ide incident as resident 1 2. Interview on 10/22/1 revealed: "He had a Brief Interv (BIMS) score 8, which cognitive impairment. "He reported that the providing care for him	is not met as evidenced ota Department of Health conline report, interviews, dicy review, the provider one resident (1) free from a error when administered an ion by director of nursing 10/4/24 complaint report medication error where she ulin (large dose) to a ver reported or counted as a intified the resident in this 24 at 2:40 p.m. with resident iew for Mental Status i indicated he had moderate staff did a good job			pharmacy consultant, and IDT review and revise the policy a procedure on insulin administ include the storage of insulin separate storage bags and to it six rights of medication admin The team also reviewed and reoles and responsibilities of the and licensed nurses to reflect responsible for insulin administration on 11/5/24. 2. Administrator did review with DON the policy for insulin administration to ensure proper administration on 11/5/24. 3. All diabetics have the potential receiving the incorrect dose/by insulin. DON or designee will educate all licensed nurses on policy of insulin administration ensure the Five Rights of Med Administration are followed by 11/15/24. 4. DON or designee will audit 3 insulin injections/week for 8 starting 11/18/24 to ensure the dose/type of insulin is being	met to met to met to met to met to met to pens in metude the metude th	
obtain blood glucose (level of sugar in blood)		insulin injections. *He was unable to rec problems getting his i 3. Interview on 10/23/ medication aide (CM/	call ever having any nsulin. 24 at 9:55 a.m. with certified A) C revealed CMAs did not			 QAPI meets monthly. DON of designee will bring audits to to meeting for review by the QA At this time a decision will be the audits to either continue or 	he PI team. made for	i i

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	readings or administs					ı		
	of nursing (DON) B n							
	regardingn resident 1	made the medication error I's insulin on 7/6/24 at 9:00						
	p.m.	lent 1 should have been						
		s of Lantus (long-acting						
		stead received 55 units of						
	Humalog (fast-acting	i) insulin.						
		rider's medication error						
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		d that resident 1 received 55 ulin instead of the ordered 62						
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1		l a contributing factor to the						
		us and Humaiog pens were						
	stored in the same balabel."	aggie in the cart with one						
	1	when DON B got a new						
		prepare to administer the resident 1's Lantus insulin,						
	_	insulin pens were two						
		identified the medication						
	error had occurred.							
		the on-call provider was						
		sulin dose was held, and the						
	resident was given a							
	taken to the hospital	that the resident was not						
	6. Review of residen record (EMR) reveal	t 1's electronic medical						
		eu. /6/24 at 9:00 p.m., "Dr.						
		ated on insulin use and that						
		is 215 with the following		1				
1	_	sugars every hour for the		1				

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		435004	B. WING_			10/24/202	4	
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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F 760	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F7	60				