STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	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 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/22/24 through 10/24/24. Areas surveyed included Nursing Services, Infection Control, Resident/Patient/Client Rights, Resident's Privacy not protected. Prairie Heights Healthcare was found not in compliance with the following requirement(s): F658, F760	F 000	Aberdeen Plan of Correction for Complaint Survey of 10/24/24. 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 act as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited or will be corrected by the dates indicated.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) complaint report, interview, record review, the provider failed to ensure services provided for four of four sampled residents (1,2,3,4,) did not meet professional standards by: *Director of nursing (DON) (B) who did not follow the rights of medication administration nor the facility policy for insulin administration when administering insulin to resident 1. *DON B who did not document a wound assessment at the time of completion or identify it as a late entry when it was documented in resident 4's medical record. *Two certified medication aides (CMA) (C and D) who did not remain within their unlicensed but certified skill set.	F 658	F658 1) Administrator, Director of Nursing (DON), Medical Director, and Interdisciplinary Team (IDT) met to review and revise as needed the policies on medication administration, insulin administration, documentation guidelines to include the acknowledgement of late entries and the roles and responsibilities of the certified medication aides to ensure professional standards in the provision of care are met on 11/5/24.	12/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darcy Albrecht — TITLE: Administrator — (X6) DATE: 11/6/24

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.

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F 658	Continued From page 1 Findings include: Surveyor 50915 1. 4. Interview on 10/23/24 at 3:30 p.m. with director of nursing (DON) B revealed: *She confirmed she made the medication error regarding resident 1's insulin on 7/6/24 at 9:00 p.m. *She confirmed resident 1 should have been administered 62 units of Lantus (long-acting insulin) insulin, he instead received 55 units of Humalog (fast-acting) insulin. 2. Review of the provider's medication error report dated 7/6/24 at 9:00 p.m. revealed: *The report confirmed that resident 1 received 55 units of Humalog insulin instead of the ordered 62 units of Lantus insulin. *The report indicated a contributing factor to the error was "Both Lantus and Humalog pens were stored in the same baggie in the cart with one label." *The report indicated when DON B got a new Lantus insulin pen to prepare to administer the remaining 7 units of resident 1's Lantus insulin, she realized that the insulin pens were two different colors, and identified the medication error had occurred. *The report indicated the on-call provider was called, the Lantus insulin dose was held, and the resident was given a snack. *The report indicated that the resident was not taken to the hospital. 3. Review of resident 1's electronic medical record (EMR) revealed: *Progress note on 7/6/24 at 9:00 p.m., "Dr. [name], on call, updated on insulin use and that	F 658	Continued from page 1 2) Administrator did review with DON the policies on medication administration, insulin administration, & documentation guidelines including the acknowledgement of late entries 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 employees C & D the certified medication aide job description to ensure they remain within their unlicensed but certified skill set; including inability to complete pain and/or psychotropic medication assessments on 11/6/24. 4) All diabetics have the potential of receiving the incorrect dose/type of insulin. DON or designee will re-educate all licensed nurses on the policy of medication and insulin administration to ensure the Five Rights of Medication Administration are followed by 11/15/24.	

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F 658	Continued From page 2 current blood sugar is 215 with the following orders: Check blood sugars every hour for the next 4 hours, 10 p.m., 11 p.m., 12 a.m., and 1 a.m. Do not give Lantus tonight. Call on call provider again in the am with the a.m. blood sugar results to see if added Lantus should be given. Pt [patient] aware, Daughter [name] updated on orders." *On 7/6/24 at 10 p.m., resident 1's blood glucose was 143 milligrams per deciliter (mg/dl). *On 7/6/24 at 11 p.m., resident 1's blood glucose was 115 mg/dl. *On 7/7/24 at 12 a.m., resident 1's blood glucose was 123 mg/dl. *On 7/7/24 at 1 a.m., resident 1's blood glucose was 118 mg/dl. *Resident 1 was given snack as order by on-call physician. -He did not show any signs of hypoglycemia. Review of the SD DOH complaint report dated 10/4/24 revealed: *The complainant wished to remain anonymous. -Director of nursing (DON) B was at a conference but had charted that she completed a wound assessment on resident 4 when she returned from the hospital 9/24/24. -DON B was not in the building at the time that resident returned from the hospital and could not have performed that assessment she documented on. -Certified medication aides completed duties outside their scope of practice. Surveyor 49238 4. Interview on 10/23/24 at 11:19 a.m. with director of nursing (DON) B revealed: *She had gone to a conference but had come back on the 10/24/24 to see resident 2 who had	F 658	Continued from page 2 5) All residents have the potential of having documentation in their medical record that has not been reflected as a late entry when needed. DON or designee will re-educate all licensed nurses on the documentation guidelines including acknowledgement of late entries to ensure accurate documentation by 11/15/24. 6) All residents have the potential of having a pain and/or a psychotropic medication assessment completed by a certified medication aide (CMA) rather than a licensed nurse. DON or designee will re-educate all licensed nurses and CMAs on the roles and responsibilities of the CMA and licensed nurse including the CMAs inability to complete pain and psychotropic medication assessments to ensure the assessments are completed by a licensed nurse by 11/15/24. 7) DON or designee will audit 3 random insulin injections/week for 8 weeks starting 11/18/24 to ensure the correct dose/type of insulin is being administered.	

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F 658	Continued From page 3 returned from the hospital. -She stated she did not feel she could depend on the nurse who had been working and wanted to see the resident herself. *She had to complete a wound assessment for resident 2 who came back from the hospital with a deep tissue injury on her heel. *She agreed she completed the documentation for that wound assessment the next day remotely. *She agreed she should have charted the wound assessment as a "late entry", but she did not. *She stated she would work Monday through Friday from 8:00 a.m. to 4:30 p.m. and sometimes stay until 5:30 p.m. and would chart remotely from home. 5. Review of medication administration records (MARs) revealed: *Certified medication aide (CMA) D had documented antipsychotic medication side effects on 8/8/24 and 8/20/24 for resident 3. *She had documented a pain assessment for resident 4 on 9/6/24. 6. Interview on 10/24/24 at 9:48 a.m. with CMA C revealed: *She stated she had not been trained on how to assess for psychotropic [brain altering medication that treat psychotic conditions such as delusions and hallucinations] medication side effects at this facility but had documented behavior information for the residents she was familiar with. -She charted yes or no answers for residents behaviors. *She stated she assessed residents for their pain level by resident's verbal answers or by the resident's facial expression and then documented their pain level. . -She would report pain levels to the nurse that	F 658	Continued from page 3 8) DON or designee will audit the prior week's documentation of 3 random residents/week for 8 weeks starting 11/18/24 to ensure any late entries are recorded as such. 9) DON or designee will audit the prior week's pain and or psychotropic medication assessment of 3 random residents/week for 8 weeks starting 11/18/24 to ensure the assessments are completed by a licensed nurse. 10) 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 resolved.	

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F 658	Continued From page 4 were five out of ten or higher. 7. Interview on 10/24/24 at 11:40 a.m. with DON B regarding CMAs completing pain and psychotropic medication assessments revealed: *DON B admitted that two CMAs (C and D) had documented pain and psychotropic medication assessments, and she had just heard about that from CMA C after her interview with the surveyors. -She said CMA C asked her today if she should have been charting those things and DON B told no. *DON B stated she was not aware they had been doing that and it was not in their scope of practice, but she had instructed them to stop. 8. Review of the providers's September 2014 Insulin administration policy revealed: *Preparation section, number three, "The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order." 9. Review of the provider's medication aide job description dated Qtr 2,2020 revealed: *"Administering Medications-Specific to Unlicensed Medication Aides." -"20. Medications administration tasks that may not be delegated to unlicensed assistive personnel (Unlicensed Medication Aides) are the following;" -"6. Exercising of nursing judgement, assessments which would require nursing intervention."	F 658		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		

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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 (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 aide (CMA) C revealed CMAs did not obtain blood glucose (level of sugar in blood)	F 760	F760 1. Administrator, DON, medical director, pharmacy consultant, and IDT met to review and revise the policy and procedure on insulin administration to include the storage of insulin pens in separate storage bags 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 on 11/5/24. 2. Administrator did review with the DON the policy for insulin administration to ensure proper insulin administration on 11/5/24. 3. All diabetics have the potential of receiving the incorrect dose/type of insulin. DON or designee will re-educate all licensed nurses on the policy of insulin administration to ensure the Five Rights of Medication Administration are followed by 11/15/24. 4. DON or designee will audit 3 random insulin injections/week for 8 weeks starting 11/18/24 to ensure the correct dose/type of insulin is being administered. 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 resolved.	12/4/24

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F 760	Continued From page 6 readings or administer insulin. 4. Interview on 10/23/24 at 3:30 p.m. with director of nursing (DON) B revealed: *She confirmed she made the medication error regardingn resident 1's insulin on 7/6/24 at 9:00 p.m. *She confirmed resident 1 should have been administered 62 units of Lantus (long-acting insulin) insulin, he instead received 55 units of Humalog (fast-acting) insulin. 5. Review of the provider's medication error report dated 7/6/24 at 9:00 p.m. revealed: *The report confirmed that resident 1 received 55 units of Humalog insulin instead of the ordered 62 units of Lantus insulin. *The report indicated a contributing factor to the error was "Both Lantus and Humalog pens were stored in the same baggie in the cart with one label." *The report indicated when DON B got a new Lantus insulin pen to prepare to administer the remaining 7 units of resident 1's Lantus insulin, she realized that the insulin pens were two different colors, and identified the medication error had occurred. *The report indicated the on-call provider was called, the Lantus insulin dose was held, and the resident was given a snack. *The report indicated that the resident was not taken to the hospital. 6. Review of resident 1's electronic medical record (EMR) revealed: *Progress note on 7/6/24 at 9:00 p.m., "Dr. [name], on call, updated on insulin use and that current blood sugar is 215 with the following orders: Check blood sugars every hour for the	F 760		

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F 760	Continued From page 7 next 4 hours, 10 pm, 11 pm, 12 am, and 1 am. Do not give Lantus tonight. Call on call provider again in the am with the 7am blood sugar results to see if added Lantus should be given. Pt [patient] aware, Daughter [name] updated on orders." *On 7/6/24 at 10 p.m., resident 1's blood glucose was 143 milligrams per deciliter (mg/dl). *On 7/6/24 at 11 p.m., resident 1's blood glucose was 115 mg/dl. *On 7/7/24 at 12 a.m., resident 1's blood glucose was 123 mg/dl. *On 7/7/24 at 1 a.m., resident 1's blood glucose was 118 mg/dl. *Resident 1 was given snack as order by on-call physician. -He did not show any signs of hypoglycemia. 7. Review of the providers's September 2014 Insulin administration policy revealed: *Preparation section, number three, "The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order."	F 760		