STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW HEALTHCARE CENTER	**401 SOUTH FIRST AVENUE PO BOX 68, WOONSOCKET, South Dakota, 57385**

(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 8/25/26 through 8/27/26. Prairie View Healthcare Center was found not in compliance with the following requirements: F641, F657, F732, F804, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/25/26 through 8/27/26. Areas surveyed nursing services, resident abuse/neglect, administration/personnel, and physical environment. Prairie View Healthcare Center was found in compliance.	F0000		
F0804 SS = F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and policy review, the provider failed to ensure that food was thawed, prepared, kept, and served at a safe temperature in one of one kitchen and that food was palatable, appetizing, and warm by two of two sampled residents (29 and 42), who reported concerns with their food. Findings include: 1. Interview on 8/25/26 at 9:43 a.m. with resident 29	F0804	1. Corrective Action for Residents Affected A. Resident #29 was interviewed regarding meal service concerns and satisfaction with food temperatures. Meal service processes were reviewed with dietary staff to ensure prompt tray delivery and temperature monitoring. B. Resident #42's concern regarding burnt pancakes was addressed immediately. Dietary staff were educated that food products that are burned, unpalatable, or do not meet quality standards are not to be served. C. All food implicated during the survey, including improperly thawed chicken, was immediately discarded. Safe food handling and thawing procedures were reimplemented. D. Food temperature monitoring was initiated for all hot foods prior to service and during tray line service to ensure food is served within acceptable temperature ranges. (Continued on next page)	10/09/2026

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
Kayla Evans	Administrator	10/07/2026

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F0804 SS = F	Continued from page 1 in her room revealed that when she ate in her room, the food was cold most of the time when she received it. She said there were rare days when the food was hot. 2. Interview and observation on 8/25/26 at 10:07 a.m. with resident 42 in his room revealed that he did not eat his breakfast. He said the food was “terrible.” His entire pancake was black on both sides. 3. Interview on 8/25/26 at 11:09 a.m. with certified nursing assistant (CNA)/cook I revealed that the cooks had menus they followed for guidance on serving sizes kept by the serving steam table. Then she explained each serving-size scoop used during the noon meal service. 4. Observation on 8/25/26 at 11:28 a.m. revealed the lunch menu was chicken, mashed potatoes, bread roll, vegetables, and gravy. The chicken and the gravy were combined during meal preparation, which was then placed on top of the mashed potatoes when served to the residents during the noon meal service. When one-half cup of mashed potatoes was served onto the plate, they did not hold their shape and spread across three-quarters of the plate. Then a 2-ounce ladle was used to put the diced chicken and gravy mixture on top, which continued to spread across the plate. The gravy was watery and see-through when plated, and the chicken did not appear to be the four ounces required by the recipe and menu. CNA/cook I checked the temperatures of the lunch food to be served to the residents. The vegetables temperature was 145 degrees Fahrenheit (F). The minced and moist chicken temperature was 131 degrees F. 5. Observation on 8/25/26 at 11:33 a.m. of CNA/cook I in the kitchen revealed she put the vegetables in the oven to reheat. 6. Interview on 8/25/26 at 11:36 a.m. with CNA/cook I revealed the vegetables and minced and moist chicken both needed to be reheated, as the food must be at 150 degrees F. She then left the kitchen/meal service to take a break. 7. Observation and interview on 8/25/26 from 11:43 a.m. to 11:49 a.m. in the kitchen revealed CNA/cook I returned to the kitchen and rechecked the food temperatures. The vegetables were 151 degrees F, and the moist and minced chicken that was left on the steam table was 130 degrees F. CNA/cook I stated “we can serve it [the moist and minced chicken] like this since we are already late, but it	F0804	2. Identification of Other Residents at Risk A. All residents receiving meals from the dietary department had the potential to be affected by the deficient practice. An audit of dietary operations, meal temperatures, tray line procedures, food presentation, and food preparation practices was completed for all meal services. 3. Systemic Changes A. All dietary staff, cooks, and dietary supervisors were educated on: Safe food temperatures, proper hot and cold holding procedures, proper thawing procedures, food presentation and portion control standards, following standardized recipes and menus and requirements for serving palatable food free from burning, overcooking and poor appearance. B. Temperature logs were revised to include: final tray temperatures and corrective actions when temperatures fall outside acceptable ranges. C. A meal tray audit process was implemented to evaluate: food appearance, portion size, temperature and resident satisfaction. D.The Regional Dietitian or designee will review dietary staffing competency and ensure ongoing supervision of meal preparation and service activities. 4. Monitoring The Administrator, Dietary Manager/designee, or Regional Dietitian will perform: A. Meal observations three-five times per week for four weeks, then weekly observations for an additional eight weeks. B. Hot food temperatures will be audited three-five times weekly for four weeks, then weekly for eight weeks. C. Audit results will be presented to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months. Additional monitoring will continue as directed by QAPI Committee.	

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F0804 SS = F	Continued from page 2 should be at 150 degrees [F].” She then said her process was to reheat the food if it did not reach the desired temperature. She then put the minced and moist chicken into the oven to reheat. At 11:49 a.m., she rechecked the temperature of the chicken, and it was 151 degrees. 8. Observation on 8/25/26 at 12:49 p.m. revealed the last room tray prepared was served to the Department of Health (DOH) surveyors; the vegetables were 108.7 degrees F, and the mashed potatoes with gravy and chicken were 123.1 degrees F. The mashed potatoes, gravy, and meat were spread across most of the plate, with the vegetables partially on top of the potatoes. The gravy was thin, watery, and see-through. The meat was approximately one ounce. 9. Interview on 8/26/26 at 8:12 a.m. with cook L revealed that she prepared and served breakfast on 8/25/26. She said, “I knew they [the pancakes] were burnt when serving, but I gave them [the residents] the ones [pancakes] that were not as black as others.” She did not expect the residents to eat burnt pancakes, but she felt she still had to serve the pancakes. 10. Interview on 8/26/26 at 9:07 a.m. with administrator A revealed she was aware the kitchen was struggling to maintain standards of the facilities and her expectations. 11. Observation and interview on 8/26/26 at 11:15 a.m. in the kitchen with cook L revealed cook L checked the temperatures of the food items in the steam table. The minced and moist vegetables were 131 degrees F, the pureed bread was 114 degrees F, the garlic bread was 106 degrees F, and the pureed vegetables were 131.2 degrees F. She expected all the food items to all be above 150 degrees F. She then placed them all in the oven to reheat. 12. Interview on 8/26/26 at 11:18 a.m. with cook N revealed the temperatures for hot foods needed to be above 150 degrees F and the temperatures for cold foods needed to be below 30 degrees F. He puréed all food that could be puréed with hot water, unless it’s a dessert; then he used milk or yogurt. He did not know what else to use other than water to puree food with. He measured the amount of liquid, based on how the food looked when it was pureed. He had no formal training, only hands-on experience from the previous cook who worked at the facility. 13. Observation on 8/26/26 at 11:20 a.m. with cook	F0804		

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F0804 SS = F	Continued from page 3 L in the kitchen revealed the reheated temperature of the moist and minced vegetables were 184 degrees F, the pureed vegetables were 172 degrees F, the pureed bread was 176 degrees F, and the garlic bread was 158 degrees F. 14. Observation on 8/26/26 at 11:23 a.m. in the kitchen sink revealed chicken thawing in a clear plastic bag, within a grey tub with water running over it from the sink faucet. 15. Interview on 8/26/26 at 11:24 a.m. with cook N regarding the food thawing process revealed food was removed the night before from the freezer and put in the fridge to thaw. The staff had forgotten to remove the frozen raw chicken from the freezer the night before, so they were thawing it by running cool water over it. Cook N checked the temperature of the water that was running over the raw chicken in the sink, which was 87.5 degrees F. Cook N said the water temperature was “okay.” and that the water was running over the chicken for about 40 minutes. The water would continue to run until he was able to break apart the raw chicken to cook. 16. Observation on 8/26/26 at 11:34 p.m. in the kitchen revealed the water continued to run over the raw chicken in the sink. 17. Interview and observation on 8/26/26 at 11:36 a.m. with regional dietitian R in the kitchen regarding the process for thawing frozen meat revealed the staff were to pull the frozen item three days before it was needed, or to use running water around 70 degrees F. She said the water should be “not too hot, and not too cold.” She was aware of the chicken thawing in the sink with running water over it. The expectation was that the chicken would thaw all the way through before cooking, because thawing partially could lead to undercooked food and be unsafe for the residents. She did not consider it safe for the water temperature thawing the chicken to be 87.5 degrees F. At 11:40 a.m., RD R checked the temperature of the water running over the frozen chicken in the sink, and it was 86.8 degrees F. She said this was not a safe thawing process, as the water was too hot, and the chicken was to be thrown away, or the residents could get sick. 18. Observation on 8/26/26 at 12:44 p.m. revealed the chicken packages were split open with the chicken still in the package, and all of the chicken was thrown in the trash.	F0804		

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F0804 SS = F	Continued from page 4 19. Interview on 8/26/26 at 4:01 p.m. with RD R revealed that there was a cleaning list for the kitchen staff, and she expected the kitchen to be clean, everything wiped down, swept, and mopped. It was normal for the kitchen to be dirty for a day but not multiple days. She expected the food to be covered when stored in the refrigerator; if it was not, it needed to be thrown away. She expected food temperatures to be checked before service and served as hot as possible on the room trays, but not as hot as if residents were eating in the dining room. She expected the food to be served within safe temperature ranges for the residents. 20. Interview on 8/26/26 at 4:16 p.m. with registered dietitian Q revealed she assisted with the cooks and dietary staff's orientation. The staff received a kitchen tour and had three days of training with someone else in the kitchen, more depending on the staff. She expected the kitchen to be clean, with items covered when stored in the refrigerator, and to dispose of expired items in the trash. She expected the staff to follow the recipes given by the company to ensure they provided adequate nutrition for the residents. She did not expect the pancakes to be served burnt to the residents. 21. Interview on 8/26/26 at 4:30 p.m. with administrator A revealed that she expected the dietary staff to know safe food temperatures to be served to the residents. She expected the cooks to know the process for thawing frozen meats at safe temperatures. She expected the kitchen to be clean of trash, food debris, and dirty wash rags. She said business office manager (BOM) G oversaw the kitchen because the facility did not have a ServSafe (a nationally recognized food and beverage safety training and certification program developed and administered by the National Restaurant Association) certified staff member or a certified dietary manager (CDM). 22. Review of the provider's October 2017 Food Storage policy revealed "Cold foods are maintained at temperatures of 41˚F [degrees Fahrenheit] or less. Hot foods leave the kitchen or steam table at 140 ˚F or above." "12. Raw eggs and thawing meats are stored in the refrigerator, preferably on the bottom shelf."	F0804		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812		

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F0812 SS = F	Continued from page 5 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, interview, and policy review, the provider failed to follow standard food safety practices to ensure two of two cooks (I and L) maintained safe food temperatures during two of two observed meal services, one of one cook (N) thawed frozen chicken safely before food preparation, and that one of one kitchen was cleaned and maintained by three of three cooks (I, L, and N). Findings include: 1. Observations on 8/25/26 from 8:09 a.m. to 8:20 a.m. in the kitchen revealed the floors by the stove, ovens, and dishwasher areas had a large amount of black film over the brown floor tiles, and trash debris including paper towels, straws, food, and wrappers. Three hard, crusted, dried washcloths, dark brown and black, were found under the handwashing sinks and under the shelving area by the stove and oven. 2. There was a frying pan hanging on the clean dishes rack with a handle that said, “the grip.” It had grease drippings, a scratched bottom surface, and a peeling non-stick coating. 3. In the walk-in refrigerator, there was a jar about one-third full of sliced pickles with no lid on the jar,	F0812	1.Corrective Action for Affected Areas A. The kitchen was immediately deep cleaned including: floors, dish washing area, clean storage areas, steam table area, equipment surfaces, plate warmer drawers, ventilation surfaces, clean dish storage, utensil containers B. All expired, uncovered, improperly stored, damaged, or potentially contaminated food items were discarded. C. The damaged skillet with peeling coating was removed from service and discarded. D. Improperly thawed chicken identified during survey was discarded immediately. 2. Identification of Other Residents at Risk A. All residents receiving meals or snacks from the dietary department had the potential to be affected by the deficient practice. A facility-wide review of food storage, sanitation, food preparation, dietary equipment, and food safety practices was completed. 3. Systemic Changes A. All dietary personnel received education and regarding: safe food handling, safe thawing procedures, food storage requirements, labeling and dating requirements, cleaning and sanitation expectations, prevention of cross-contamination and hand hygiene and glove use B. A comprehensive dietary sanitation checklist was implemented requiring daily documentation of: floors, equipment, shelving, dish washing area, refrigerators and freezers and food storage areas C. Temperature monitoring logs were revised to ensure appropriate hot and cold food holding temperatures. D. The facility will ensure a qualified individual with documented food safety training oversees dietary operations. Ongoing consultation with the Regional Dietitian has been implemented. E. Monthly dietary rounds were added to the Quality Assurance Performance Improvement (QAPI) program. (Continued on next page)	10/09/2026

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F0812 SS = F	Continued from page 6 located on the top shelf in the fridge. 4. There was a Pure Life gallon of water, about a quarter full, with multiple black dots that appeared to be mold on the inside and outside of the gallon jug. 5. There was a large metal bowl of pudding dated 8/25/26 with no cover over the container, and a package of string cheese and an orange on the refrigerator floor. 6. In the walk-in freezer there were multiple boxes of strawberry shakes opened, falling onto the floor under the shelving. 7. Interview on 8/25/26 at 9:43 a.m. with resident 29 in her room revealed that when she ate in her room, the food was cold most of the time when she received it. She said there were rare days when the food was hot. 8. Observation on 8/25/26 at 11:00 a.m. revealed cook L delivered the uncovered pudding from the fridge to the dining room tables for lunch. 9. Interview on 8/25/26 at 11:04 a.m. with certified nursing assistant (CNA)/cook I revealed that if the pudding was stored uncovered in the fridge, then it should not be served to the residents, and she would need to make new pudding. 10. Observation on 8/25/26 at 11:06 a.m. revealed that cook L removed the pudding from the dining room tables, and CNA/Cook I remade the pudding for the lunch service. 11. Observation and interview on 8/25/26 from 11:15 a.m. to 11:36 a.m. in the kitchen with CNA/cook I revealed the cooking area floors remained unchanged and dirty with debris, as earlier in the morning. The grill and stove had pancake batter from the breakfast meal service. The frying pan with “the grip” handle remained hanging on the clean dish rack with grease and peeling nonstick coating. 12. There was a whole sausage patty and brown ground-up pieces of meat on the floor by the steam table from the breakfast meal service. 13. There were two large storage containers of white sugar and flour, both with expiration dates of 6/30/26. 14. On the clean dishes shelving there was a silver tray, a clear glass dish, and a white serving tray with food debris and trash on them. There were four grey	F0812	4. Monitoring A. The Administrator, Dietary Manager/designee, and/or Regional Dietitian will complete: daily kitchen sanitation audits three-five days per week for four weeks, then weekly audits for eight additional weeks B. Food storage and expiration date audits will be conducted weekly for 12 weeks. C. Food temperature audits will be conducted three-five times weekly for four weeks and weekly thereafter for eight weeks. D. Audit findings will be reviewed by the QAPI Committee monthly for three months with additional follow-up as indicated.	

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F0812 SS = F	Continued from page 7 baskets that held the clean serving utensils and lids to the pitchers that had food debris in the bottom of the containers. A dried banana slice was on the floor by the clean dishes shelving. 15. At 11:28 a.m. CNA/cook I checked the temperatures of the lunch food to be served to the residents. The lunch meal was scheduled to be served at 11:30 a.m. The vegetables temperature was 145 degrees Fahrenheit (F). The minced and moist chicken temperature was 131degrees F. 16. CNA/Cook I put the vegetables in the oven to reheat. 17.CNA/Cook I said the vegetables and minced and moist chicken would both need to be reheated, as the food must be at 150 degrees. She then left the kitchen to take a break. 18. Observation and interview on 8/25/26 from 11:43 a.m. to 11:49 a.m. in the kitchen revealed CNA/cook I returned to the kitchen and rechecked the food temperatures. The vegetables were 151 degrees F, and the moist and minced chicken that was left on the steam table was 130 degrees F. CNA/cook I stated “we can serve it [the moist and minced chicken] like this since we are already late, but it should be at 150 degrees [F].” She then said her process was to reheat the food if it did not reach the desired temperature. She then put the minced and moist chicken into the oven to reheat. At 11:49 a.m., she rechecked the temperature of the chicken, and it was 151 degrees. 19. Interview on 8/25/26 at 12:12 p.m. with business office manager (BOM) G revealed she threw “the grip” large skillet away from the clean dishes rack because the bottom of the non-stick pan was peeling due to the use of metal on the pan, so the staff could no longer use it. 20. Observation on 8/25/26 at 12:19 p.m. of cook L and CNA/cook I in the kitchen revealed they prepared resident room trays. 21. Observation on 8/25/26 at 12:49 p.m. revealed the last room tray was served to the Department of Health (DOH) surveyors. The vegetables were 108.7 degrees F, and the mashed potatoes with gravy and meat were 123.1 degrees F. 22. Observations and interview on 8/26/26 from 8:03 a.m. to 8:08 a.m. in the kitchen with cook N revealed the dishwashing area continued to have the black film over the brown floor tiles. The trash	F0812		

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F0812 SS = F	Continued from page 8 debris remained on the floor. The food debris remained under the stove and ovens. The washcloths and trash debris remained under the shelving between the stove and ovens. The dried banana slice remained on the floor by the clean shelving, and the dirty dishes remained on the clean shelving, including the silver platter, white platter, and clear dish with food debris and trash on them. 23. The large white flour storage bin had the expiration date of 6/30/26. The white sugar storage bin had an “8” written over 6/30/26 to appear to be changed to “8/30/26.” 24. Cook N stated the stovetops and griddles were cleaned weekly by soaking them and running them through the dishwasher. He removed the stove cooktop plates to clean them. 25. The pickles remained uncovered on the top shelf in the walk-in fridge. 26. Interview and observations on 8/26/26 from 8:14 a.m. to 8:29 a.m. with cook L in the kitchen revealed that the resident diet cards were printed each night for use the next day. 27. The bins the clean utensils were in continued to have food debris in them. 28. The vent above the steam vent above the steam table continued to have black buildup inside of the metal area of the vent. 29. The two plate warmer drawers that held clean plates continued to have food debris at the bottom of both drawers. 30. At 8:27 a.m. Cook L touched the eating surfaces of the plates with her bare hands after wiping her face, touching the drawer handle, and the countertop that had food debris on it. 31. The microwave used to heat the resident’s food continued to have the same food debris as at lunchtime on 8/25/26. 32. Interview on 8/26/26 at 9:07 a.m. with administrator A revealed she was aware the kitchen was struggling to maintain standards of the facilities and her expectations. 33. Observation on 8/26/26 at 11:14 a.m. in the kitchen revealed there were missing baseboard tiles on the wall separating the stove and the clean dishes area. The exposed wood had dark brown	F0812		

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PRAIRIE VIEW HEALTHCARE CENTER	**401 SOUTH FIRST AVENUE PO BOX 68, WOONSOCKET, South Dakota, 57385**

(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
F0812 SS = F	Continued from page 9 areas approximately four inches long on the front side and two inches long on both sides. 34. Observation and interview on 8/26/26 at 11:15 a.m. in the kitchen with cook L revealed cook L checked the temperatures of the food items in the steam table. The minced and moist vegetables were 131 degrees F, the pureed bread was 114 degrees F, the garlic bread was 106 degrees F, and the pureed vegetables were 131.2 degrees F. She expected all the food items to all be above 150 degrees F. She then placed them all in the oven to reheat. 35. Interview on 8/26/26 at 11:18 a.m. with cook N revealed the temperatures for hot foods needed to be above 150 degrees F and the temperatures for cold foods needed to be below 30 degrees F. 36. Observation on 8/26/26 at 11:20 a.m. with cook L in the kitchen revealed the reheated temperature of the moist and minced vegetables were 184 degrees F, the pureed vegetables were 172 degrees F, the pureed bread was 176 degrees F, and the garlic bread was 158 degrees F. 37. Observation on 8/26/26 at 11:23 a.m. in the kitchen revealed chicken thawing in sealed plastic, within a grey tub in the kitchen sink with running water over it. 38. Interview on 8/26/26 at 11:24 a.m. with cook N revealed that the thawing process for food was that the food was removed the night before from the freezer, but since the staff forgot to remove the food, they could thaw it by running cool water over the food. Cook N then took the temperature of the water that was running over the chicken in the sink at 87.5 degrees F. Cook N said the water temperature was “okay, since it’s the cool water running.” Cook N said the water has been running over the chicken for about 40 minutes. The water would continue to run until he was able to break apart the chicken for cooking preparation. 39. Observation on 8/26/26 at 11:23 a.m. in the kitchen sink revealed chicken thawing in a clear plastic bag, within a grey tub with water running over it from the sink faucet. 40. Interview and observation on 8/26/26 at 11:36 a.m. with regional dietitian R in the kitchen regarding the process for thawing frozen meat revealed the staff were to pull the frozen item three days before it was needed, or to use running water around 70 degrees F. She said the water should be “not too hot, and not too cold.” She was aware of the	F0812		

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F0812 SS = F	Continued from page 10 chicken thawing in the sink with running water over it. The expectation was that the chicken would thaw all the way through before cooking, because thawing partially could lead to undercooked food and be unsafe for the residents. She did not consider it safe for the water temperature thawing the chicken to be 87.5 degrees F. At 11:40 a.m., RD R checked the temperature of the water running over the frozen chicken in the sink, and it was 86.8 degrees F. She said this was not a safe thawing process, as the water was too hot, and the chicken was to be thrown away, or the residents could get sick. 41. Observation on 8/26/26 at 12:44 p.m. revealed the chicken packages were split open with the chicken still in the package, and all of the chicken was thrown in the trash. 42. Interview on 8/26/26 at 4:01 p.m. with RD R revealed that there was a cleaning list for the kitchen staff, and she expected the kitchen to be clean, everything wiped down, swept, and mopped. It was normal for the kitchen to be dirty for a day but not multiple days. She expected the food to be covered when stored in the refrigerator; if it was not, it needed to be thrown away. She expected food temperatures to be checked before service and served as hot as possible on the room trays, but not as hot as if residents were eating in the dining room. She expected the food to be served within safe temperature ranges for the residents. 43. Interview on 8/26/26 at 4:16 p.m. with registered dietitian Q revealed she assisted with the cooks and dietary staff's orientation. The staff received a kitchen tour and had three days of training with someone else in the kitchen, more depending on the staff. She expected the kitchen to be clean, with items covered when stored in the refrigerator, and to dispose of expired items in the trash. 44. Interview on 8/26/26 at 4:30 p.m. with administrator A revealed that she expected the dietary staff to know the temperatures the food should be served at to be safe; she expected the room trash to have safe, hot food temperatures. She expected the cooks to know the process for thawing frozen meats at safe temperatures. She expected the kitchen to be clean of trash, food debris, and dirty wash clothes. She said BOM G oversees the kitchen at this time because the facility does not have anyone with ServSafe (a nationally recognized food and beverage safety training and certification program developed and administered by the National	F0812		

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F0812 SS = F	Continued from page 11 Restaurant Association) or a certified dietary manager (CDM). 45. Review of the provider's updated October 2017 Food Storage policy revealed “Procedure: 1. Food storage areas are kept clean at all times. 4. Remove food from the packing boxes upon delivery (to minimize pests). Loose items such as cookies and crackers are placed in containers or bins. Empty food cans are not used. Only food grade reusable containers are used for food storage. 5. Foods are dated with month and year of delivery to the Center. Exceptions: Food items with used by dates of less than 30 days (e.g. milk, cottage cheese, fresh bread, and produce) do not require labeling with the month and year of delivery. 6. Food products are used within one year unless the manufacturer’s expiration date is different. 7. Cold foods are maintained at temperatures of 41˚F [degrees Fahrenheit] or less. Hot foods leave the kitchen or steam table at 140 ˚F or above. 10. Opened items have “use by” dates indicated on them. This “use by” date may be circled to differentiate it from the date received or date opened. May indicate date opened or date prepared if required by your survey agency. 11. The manufacturer’s expiration date, when available, is the use by date for unopened items. 12. Raw eggs and thawing meats are stored in the refrigerator, preferably on the bottom shelf. 13. Supplemental shakes, which are taken from the frozen state and thawed in the refrigerator, are dated with use by dates when they are placed in the refrigerator. Follow the manufacturer’s recommendations for shelf life. 46. Review of the provider’s updated September 2019 Sanitation policy revealed “ Procedure: 1. Kitchens, kitchen areas, and dining areas are kept clean, free from litter and rubbish, and protected from rodents, roaches, flies and other insects. 2. Utensils, counters, shelves, and equipment are kept clean, maintained in good repair, and are free from breaks, corrosion, open seams, cracks, and chipped areas. 7. Cleaning schedules are developed by the FANS Manager or Person in Charge. 8. The FANS [Food and Nutritional Services] Manager or Person in Charge monitors compliance to the cleaning schedule. 47. Review of the provider's updated December 2025 Keeping Resident Food Safe Policy revealed " cooked chicken, turkey, and stuffed foods to 165 degrees F."	F0812		

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F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	1. Corrective Action for Residents Affected A. Residents #1, #3, #4, #9, and #25 identified during the survey were immediately reviewed by the Director of Nursing to verify the appropriate Transmission-Based Precautions, Enhanced Barrier Precautions (EBP), physician orders, care plans, and required signage. Transmission-Based Precaution and Enhanced Barrier Precaution signage was verified and/or placed on resident room doors as indicated for all residents. Residents with indwelling devices, including urinary catheters, suprapubic catheters, and gastrostomy tubes, were reviewed to ensure EBP requirements were clearly identified within the medical record and care plan. Nursing staff directly involved in the deficient practice received education regarding hand hygiene, Enhanced Barrier Precautions, and proper wound care protocols. The facility verified that residents requiring Enhanced Barrier Precautions and Transmission-Based Precautions were appropriately identified and communicated through signage and clinical documentation. No residents were identified as experiencing a negative outcome as a result of the deficient practices observed during the survey. 2. Identification of Other Residents at Risk A. A 100% audit was completed for all residents on Enhanced Barrier Precautions and Transmission-Based Precautions, as well as residents with multidrug-resistant organisms (MDROs), indwelling urinary catheters, suprapubic catheters, gastrostomy tubes, or wound care treatments. The audit included a review of appropriate Transmission-Based Precaution orders, the presence and accuracy of precaution signage, and care plan and Kardex documentation. Any concerns identified were corrected immediately through physician notification, care plan revision, signage placement, and staff education. (Continued on next page)	10/09/2026

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F0880 SS = F	Continued from page 13 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure infection prevention and control practices were followed by one of one registered nurse (RN) (E) and one of one licensed practical nurse (LPN) (F) who did not use enhanced barrier precautions (EBP), including gown and glove use, while changing wound dressings for three of three residents (1, 9, and 25) on EBP and one of one LPN (F) who did not use EBP when administering medications to one of one resident (3), who had a gastrostomy tube (a soft, flexible tube placed through the abdomen directly into the stomach) and a suprapubic catheter (a thin, flexible tube inserted through the lower abdomen into the bladder) and was on EBP. Findings include: 1. Observation on 8/25/26 at 8:52 a.m. revealed resident 9 did not have an EBP sign on his door as RN E entered his room to complete his wound care to his legs. 2. RN E entered resident 9's room to complete his wound care to his legs. She did not perform hand hygiene before applying gloves. RN E touched the exterior of both dressings, which did not have a date. She did not complete hand hygiene (involves	F0880	3. Systemic Changes A. All clinical staff were educated regarding CDC guidance related to Enhanced Barrier Precautions and Transmission-Based Precautions, identification of residents requiring Contact Precautions and Enhanced Barrier Precautions and required PPE use when providing care involving indwelling medical devices, including Foley catheters, suprapubic catheters, and gastrostomy tubes. B. All licensed nurses were educated on proper wound care infection control practices and the required use of PPE during medication administration through gastrostomy tubes. C. The Director of Nursing Services or Designee will maintain an active roster of residents requiring Transmission-Based Precautions and Enhanced Barrier Precautions. The roster will be reviewed weekly and updated as necessary to ensure residents are appropriately identified. D. All licensed nursing staff completed return demonstrations and competency validations on Transmission-Based Precautions, Enhanced Barrier Precautions, wound care procedures, Foley and suprapubic catheter care, and gastrostomy tube care and medication administration. 4. Monitoring A. The Director of Nursing Services or designee will conduct audits to evaluate appropriate Transmission-Based Precaution (TBP) and Enhanced Barrier Precaution (EBP) signage, proper PPE use during wound care, proper PPE use while providing care for residents with indwelling devices, proper PPE use while administering enteral medications, and care plan accuracy. (Continued on next page)	

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F0880 SS = F	Continued from page 14 either handwashing with soap and water or using alcohol-based hand rubs (hand sanitizer) to remove or kill harmful germs) before she put on a pair of gloves and did not put on a gown. She removed the previous dressing from the right leg wound and did not remove her soiled gloves or clean the wound area before she applied a skin prep (a liquid that forms a thin barrier between the adhesive dressing and the skin) and applied a new adhesive dressing to his right leg wound. Her soiled glove had touched the clean surface of the clean dressing that touched the wound area. 3. Interview on 8/25/26 at 1:51 p.m. with CNA T revealed she was not sure if the contact precautions sign was for resident 1, or his previous roommate. 4. Observation on 8/26/26 at 7:44 a.m. revealed RN E did not use the required enhanced barrier precautions of wearing a gown when she provided wound care to resident 25's pressure injury on his left heel. 5. Observation on 8/26/26 at 9:00 a.m. revealed resident 9's room had an EBP sign on the door. 6. Observation on 8/26/26 at 9:01 a.m. revealed resident 45 had a contact precaution sign on their door. 7. Observation on 8/26/26 at 9:03 a.m. revealed resident 3 had an EBP sign on his door. 8. Observation on 8/26/26 at 9:05 a.m. revealed resident 4 had an EBP sign on their door. 9. Review of resident 9's EMR revealed he admitted to the facility on 6/5/25. His 7/23/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. 10. Review of resident 4's EMR revealed he admitted to the facility on12/1/25. His 5/28/26 BIMS assessment score was 8, which indicated his cognition was moderately impaired. His undated care plan indicated he was on EBP due to having an indwelling urinary catheter (flexible tubing placed in the bladder to drain urine). 11. Review of resident 1's EMR revealed he admitted to the facility on 12/2/25. His 6/15/26 BIMS assessment score was 13, which indicated his cognition was intact. He had a diagnosis of extended-spectrum beta-lactamase (ESBL) (enzymes that break down common antibiotics, so those antibiotics stop working and the infections become	F0880	B. The Director of Nursing Services or designee will conduct audits of Transmission-Based Precaution and Enhanced Barrier Precaution signage, wound care, indwelling catheter care, and administration of enteral medications with 3-5 observations weekly for 4 weeks, then weekly for 8 weeks thereafter to ensure adherence to the facility's Infection Prevention and Control policies and procedures. Any concerns identified will be corrected immediately. C. Audit results will be reviewed through the QAPI process. Additional education and corrective actions will be implemented as needed to ensure ongoing compliance.	

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F0880 SS = F	Continued from page 15 harder to treat). His undated care plan indicated he was on EBP due to his ESBL diagnosis. It was identified that this was in his urine. 12. Review of resident 45's EMR revealed she admitted to the facility on 8/10/26. Her 8/21/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included a fractured humerus in her right arm, and resistant Staphylococcus aureus infection (an illness caused by Staphylococcus aureus bacteria, which could live on the skin or in the nose and could cause serious infections if they enter the bloodstream, lungs, or other organs). Her undated care plan indicated that she was on EBP due to a skin opening requiring a dressing change. 13. Observation on 8/26/26 at 9:18 a.m. of resident 3's medication administration in his room with LPN F revealed there was an EBP sign on the door. LPN F entered resident 3's room with the medication cart, washed her hands in the bathroom, placed a barrier on resident 3's bedside table, prepped five medication cups with one medication each at the medication cart, put on a pair of gloves, and administered 30 milliliters (mL) of water via resident 3's gastrostomy tube. She then administered the prepared five medications with a syringe into resident 3's gastrostomy tube followed by another 30 mL of water. LPN F did not put on a gown anytime during the medication administration process with resident 3. 14. Review of resident 3's electronic medical record (EMR) revealed he was admitted to the facility on 6/5/26. He had a diagnosis of dysphagia, oropharyngeal phase (difficulty moving food and liquid from mouth into throat and upper esophagus). He had an 8/12/26 physician's order for EBP due to an indwelling catheter and gastrostomy tube. His care plan indicated the staff were to follow EBP interventions due to his indwelling catheter and gastrostomy tube initiated on 6/23/26. The interventions for EBP involved gown and glove use during high-contact activities, which included dressing, bathing/showering, transferring, changing linens, changing briefs, assisting with toileting, device care/use, and wound care. 15. Observation on 8/26/26 at 9:57 a.m. revealed LPN F completed resident 1's wound care to both of his arms without wearing a gown. 16. Observation on 8/26/26 at 10:57 a.m. in resident 9's room with LPN F revealed she did not use EBP before she changed the dressings to both of	F0880		

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F0880 SS = F	Continued from page 16 resident 9's legs. She did not clean the wound area before the new dressings were applied. 17. Interview on 8/26/26 at 12:49 p.m. with CNA T revealed the EBP and contact precaution signs were put up before she arrived for her shift that morning. She thought that resident 45 was on contact precautions because she had some cuts on her arms from surgery and resident 1's EBP sign was on his door because of his roommate who passed away on 8/25/26. The EBP signs for residents 3, 4, and 6 were for their catheters. She was aware that EBP needed to be worn for direct patient care. 18. Interview on 8/26/26 at 1:16 p.m. with RN E revealed that yesterday (8/25/26) the EBP and contact signs were put on the residents' doorways. Residents 12 and 45's signs were added because resident 45 was being treated for a urinary tract infection until the culture comes back to the provider. She said contact precautions was done all the time when you enter the resident's room who was on isolation precautions. The staff should follow EBP when they were going to be in direct contact with the resident. She did not know the process for a resident on isolation precautions sharing a room with another resident. 19. Interview on 8/26/26 at 1:23 p.m. with director of nursing (DON) B revealed that when isolation precaution signs needed to be changed or switched to alternate precautions, then a staff member removed all the signage, which was why they were not originally posted on the residents' doors. If a resident on contact precautions shared a room, then the contact precautions should be worn while providing care for both residents and changed between different residents' cares. If the provider had an open room, they would move the resident; if not, they would increase the cleaning schedule. She expected the nursing staff to know who was on isolation and why. Contact precautions PPE should be used when entering the room. She expected the staff to use EBP personal protective equipment (PPE) for direct patient care. 20. Interview on 8/26/26 at 1:29 p.m. with medical director (MD) S revealed he expected the staff to clean the resident's wounds or skin areas before they applied a clean dressing to the area. He expected facility staff to follow EBP and contact precautions and wear appropriate PPE when caring for patients to prevent the spread of infections. 21. Interview on 8/27/26 at 7:57 a.m. with LPN F revealed she did not think she needed to use EBP	F0880		

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F0880 SS = F	Continued from page 17 while administering medications through resident 3's gastrostomy tube. She agreed that EBP should be used for indwelling devices, which included gastrostomy tubes. She then agreed that she "probably" should have been using EBP while administering resident 3's medications through his gastrostomy tube on 8/26/26. 22. Review of the provider's updated March 2026 Transmission-Based Precautions (Isolation) policy revealed "Transmission-Based Precautions (previously referred to as isolation precautions) are implemented for residents known to be, or suspected of being, infected with infectious agents. Procedure: 3. The need to implement Transmission-Based Precautions is determined by the facilities Infection Preventionist (IP), Director of Nursing and/or consultation with the local health department. Precautions are based on CDC [center for disease control] guidelines. Precautions are the least restrictive possible for the resident. 4. The facility documents in the resident's medical record the rationale for the type of transmission-based precautions selected as well as the length of time the precautions are maintained. 5. Communication of Transmission-Based Precautions is accomplished with pertinent signage and verbal reports to personnel and visitors. 6. Residents on TBP, apart from EBP, should remain in their room for the duration of precautions, except for medically necessary care or resident choice. 7. Indirect transmission of infectious agents can occur through contact with resident care equipment. Contact Isolation Precautions: Personnel having contact with the infected resident should wear gloves and a gown. Prior to leaving the resident's room, gown and gloves are removed and hand hygiene performed. Options for residents on contact precautions may include a private room, cohorting with another infected or colonized resident or sharing a room with a resident with limited risk factors (no immunosuppression, IV's, indwelling catheters or open skin lesions). Residents with wound drainage, fecal incontinence, or diarrhea that cannot be contained should be placed on contact precautions until a specific organism of the origin of the medical issues is identified. Enhanced Barrier Precautions: involve the use of gown and gloves by care providers, during high-contact resident care activities. EBP are used when caring for residents with colonization or infection with a targeted and epidemiologically important MDRO [multidrug-resistant organism], chronic wounds, or indwelling medical device/s."	F0880		

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F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure one of four sampled residents' (30) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the area of Pre-Admission Screening and Resident Review(a federal requirement that ensures individuals with serious mental illness, intellectual	F0641	1. Corrective Action for Residents Affected A. The identified resident's MDS assessments were reviewed and corrected to accurately reflect the resident's condition. B. The care plans were reviewed and updated as needed. 2. Identification of Other Residents at Risk A. The MDS Coordinator reviewed MDS assessments completed in the last 30 days to identify any additional inaccuracies. Any concerns identified were corrected. 3. Systemic Changes A. The MDS Coordinator and interdisciplinary team were educated on accurate MDS coding and the requirement that coding must be supported by medical record documentation. B. An audit process was implemented prior to MDS submission to ensure accuracy. 4. Monitoring: A. The Director of Nursing or designee will audit 3 MDS assessments weekly for 4 weeks, then monthly for 2 months to verify accuracy and supporting documentation. B. Findings will be reviewed through the facility's QAPI process, and additional education will be provided as needed.	10/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2026

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F0641 SS = D	Continued from page 19 disabilities, or related conditions are not inappropriately placed in nursing homes and receive appropriate services) (PASRR), and one of three sampled residents' (20) MDS assessment was accurately coded for the area of special treatments, procedures, and programs. Findings include: 1. Review of resident 20's electronic medical record (EMR) revealed he admitted to the facility on 12/30/25. His 8/18/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated his cognition was moderately impaired. He had a 2/23/26 diagnosis of Senile degeneration of the brain. He had a 2/23/26 physician's order to be admitted to hospice services provided by Avera Hospice. Resident 20's 5/28/26 quarterly MDS Assessment Section O question "O0110 Special Treatments, Procedures, and Programs K1 Hospice Care" was marked "no" by former MDS P. 2. Interview and EMR review on 8/27/26 at 11:32 a.m. with MDS D revealed she had started completing the residents' MDS Assessments in July 2026. She confirmed that resident 20's 5/28/26 quarterly MDS Assessment was completed remotely by former MDS P. She agreed that Section O question O0110 K1 was marked wrong and should have been marked "yes" as he was on hospice at that time. She confirmed she used the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 to complete the resident's MDS assessments. She referred to the residents' diagnoses and physician's orders to complete the resident MDS assessment. 3. Review of resident 30's EMR revealed she admitted to the facility on 4/13/26. Her 7/17/26 Brief Interview for Mental Status (BIMS) assessment score was 10 which indicated her cognition was moderately impaired. She had a diagnosis of Huntington's Disease (a fatal inherited genetic disorder that causes the progressive breakdown of nerve cells in the brain), and Schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves, often making it hard to tell what is real and what is imaginary) dated 4/8/26.	F0641		

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F0641 SS = D	Continued from page 20 Resident 30 had a 4/9/26 Maximus (a federally mandated program used to evaluate individuals with serious mental illness, intellectual disabilities, or developmental disabilities before they are admitted to reside in a Medicaid-certified nursing facility) notice of PASRR Level 1 screen outcome. It indicated if a resident was currently in a Medicaid-certified nursing facility, the facility would need to document their PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for question A1500 on the MDS assessment. “Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition?” Also, their specific PASRR condition(s) should be checked in question A1510, “Level II Preadmission Screening and Resident Review (PASRR) Conditions.” Resident 30’s 4/18/26 admission MDS Assessment, Level II PASRR question A1500 was marked “no” by former MDS P. There was no ability to answer A1510 and list the resident’s diagnosis. 4. Interview and EMR review on 8/27/26 at 11:41 a.m. with MDS D revealed that resident 30’s 4/9/26 Maximus notice of PASRR Level 1 screen outcome letter indicated that resident 30’s 4/18/26 MDS assessment question A1500 should have been marked “yes” by former MDS P when she completed the assessment. That would have made question A1510 available to put in resident 30’s current diagnosis. 5. Interview on 8/27/26 at 11:48 a.m. and 11:54 a.m. with director of nursing (DON) B revealed resident 30’s 4/18/26 admission MDS assessment section A question A1500 was marked incorrectly by former MDS P and should have been marked “yes”, which would have enabled question A1510 to be answered. She agreed that resident 20’s 5/28/26 quarterly MDS assessment section O question O0110 K1 was marked “no”, incorrectly and it should have been marked yes by former MDS P. She expected the MDS assessment to be completed correctly to represent the care the residents were provided. 6. Review of the CMS Long-Term Care Facility RAI 3.0 User’s Manual Version 1.20.1 October 2025 revealed section A, item A1500 indicated to “Code 1, yes if PASRR Level II screening determined that the	F0641		

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F0641 SS = D	Continued from page 21 resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition" and section O revealed item O0110 K1 Hospice Care Code residents identified as being in a hospice program for terminally ill persons where an array of services was provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure residents' care plans (a personalized plan addressing a resident's care needs, goals, and interventions) were reviewed and revised to reflect	F0657	1. Corrective Action for Residents Affected A. Resident #3's comprehensive care plan, Kardex, and clinical documentation were reviewed and revised to accurately reflect the presence of a suprapubic catheter, catheter care requirements, catheter site care, monitoring parameters, and resident-specific interventions. B. The resident's physician orders and treatment documentation were reviewed to ensure consistency with the care plan and Kardex. C. Nursing staff were educated regarding the resident's catheter type and required care. D. Resident #6's comprehensive care plan, Kardex, and clinical documentation were reviewed and revised to accurately reflect his buttock wound, repositioning needs, pressure-relieving interventions, skin integrity concerns, and individualized interventions necessary to prevent further skin breakdown. E. Nursing staff were educated regarding the resident's wound care needs, repositioning assistance requirements, and pressure-relieving interventions. Any discrepancies identified between physician orders, treatment records, care plans, and Kardex documentation were corrected. (Continued on next page)	10/09/2026

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F0657 SS = D	Continued from page 22 the current care needs for one of two sampled residents (3) who had a suprapubic catheter (a thin, flexible tube inserted directly into the urinary bladder through a small incision in the lower abdomen), and for one of two sampled residents (6) who had a wound on his buttocks. Findings include: 1. Interview on 8/25/26 at 9:02 a.m. with resident 3 revealed he had a catheter “coming from his stomach.” He had the catheter for approximately four months because he had to urinate every hour of the day before he had the catheter put in. 2. Review of resident 3’s electronic medical record (EMR) revealed he admitted to the facility on 6/5/26. His 6/5/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. His diagnoses included amyotrophic lateral sclerosis (ALS) (a disease or motor neuron disease, a progressive neurodegenerative disorder affecting the brain and spinal cord), retention (inability to empty the bladder) of urine, and benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (an enlarged prostate that makes it harder to urinate). His undated care plan indicated that he had an indwelling catheter that needed to be anchored to prevent tension for urethral tears, erosion, or dislodging. The staff was to provide catheter care every shift. The goals for resident 3 were to have no indication of pain, urethral erosion, or other significant complications associated with an indwelling catheter. He had a 6/5/26 physician’s order for a suprapubic catheter, and a 8/26/26 physician’s order for the suprapubic catheter site to be cleaned with wound cleanser and a T-sponge (a medical sponge used to absorb fluids and protect tissues) to be applied daily and as needed (PRN). 3. Observation on 8/26/26 at 2:23 p.m. with licensed practical nurse (LPN) F while she completed resident 6’s wound care revealed she performed hand hygiene (the practice of cleaning your hands with soap and water or alcohol-based hand rub) and applied a gown and gloves. She transferred resident 6 using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) from his wheelchair to the toilet in his bathroom. LPN F removed the soiled wound dressing and cleansed the area with wound cleanser. The area was allowed	F0657	2. Identification of Other Residents at Risk A. A 100% audit of current residents was completed by the Director of Nursing to verify that care plans and Kardexes accurately reflect current resident wounds, catheters, indwelling devices, skin concerns, and pressure-relieving devices. The audit included verification that: Residents with urinary catheters have the specific catheter type identified in the care plan and Kardex. Residents receiving catheter care have appropriate interventions identified in the care plan. Residents with wounds have wound-related interventions incorporated into the care plan. Pressure-relieving devices, cushions, and skin integrity interventions are accurately reflected in the care plan. Any deficient findings identified during the audit were corrected immediately. 3. Systemic Changes A. All licensed nurses, MDS staff, and interdisciplinary team members were educated regarding comprehensive care planning requirements, including the need to review and revise care plans when resident conditions, physician orders, treatments, wounds, devices, or care needs change. B. The MDS Coordinator, Director of Nursing, or designee will review new admissions, readmissions, significant changes, new wounds, catheter insertions, treatment changes, and new physician orders to ensure timely revisions to the resident's care plan and Kardex. (Continued on next page)	

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F0657 SS = D	Continued from page 23 to air dry. Her gloves were changed, and hand hygiene was performed. She applied Medihoney (a medical-grade wound dressing made from Active Leptospermum (Manuka) honey) and then applied a bordered gauze dressing to each buttock and dated them using a black permanent marker. 4. Review of resident 6's EMR revealed that he admitted to the facility on 2/5/26. His 6/9/26 BIMS assessment score was 14, which indicated his cognition was intact. His diagnoses included BPH without lower urinary tract symptoms, malignant neoplasm of the bladder (bladder cancer), memory deficit, weakness, extended spectrum beta lactamase (ESBL) (are enzymes made by certain bacteria that break down and resist many common antibiotics, making infections harder to treat), reduced mobility, pyogenic arthritis (septic arthritis, a serious infection in a joint caused primarily by bacteria), spinal stenosis, and polyneuropathy (a type of peripheral neuropathy where multiple peripheral nerves across the body are damaged). His undated care plan indicated that he had the potential for skin impairment. There was no documentation of a wound to his buttocks or interventions for repositioning assistance by the staff documented on his care plan. His orders indicated his dressing to his buttocks was to be completed daily for excoriation (a scratch or abrasions to the skin). 5. Interview on 8/26/26 at 3:16 p.m. with LPN F revealed that the facility did not have an order to provide catheter care on the treatment administration record. Nurses were expected to complete this care for his suprapubic catheter. The nurses would not know to complete the catheter care if the order was not on the TAR. 6. Observation on 8/26/26 at 3:19 p.m. revealed LPN F and certified nursing assistant (CNA) M completed resident 3's catheter care. 7. Interview on 8/27/26 at 8:09 a.m. with CNA H revealed she used the Kardex (a report of the resident's care needs and interventions) to know how to take care of her assigned residents. If the information was not on the Kardex, she would not know how to take care of her assigned residents. If the information was not on the Kardex, she would not know the necessary care for the resident. She expected the resident's care plan to specify what kind of catheter a resident had because different types of care were necessary for each. She confirmed by looking at the kardex that resident 3's	F0657	4) Monitoring A. The Director of Nursing, MDS Coordinator, or designee will conduct audits of resident care plans and Kardex's to verify: Current resident conditions are accurately reflected. Catheter types and catheter care requirements appropriately care planned. Wounds and skin concerns appropriately care planned. Repositioning and pressure-relieving interventions are included when indicated. B. 3-5 resident audits will be conducted weekly for 4 weeks, then weekly for 8 weeks. C. Any concerns identified will be corrected immediately. Audit results will be reviewed through the QAPI process. Additional education and corrective actions will be implemented as needed to ensure ongoing compliance.	

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F0657 SS = D	Continued from page 24 kardex did not indicate his catheter type. She stated that resident 6 was able to reposition himself in small adjustments, but he did need one staff member's assistance to completely offload his weight from his buttocks. The staff did not document repositioning or when it occurred, but they repositioned him about every two hours and whenever he requested additional assistance with position changes. She would find the information on when and how to reposition residents, what pressure-relieving cushions were used, and if the resident was incontinent (involuntary urine or bowel leakage) or wore incontinent supplies in the kardex. 8. Interview on 8/27/26 at 11:53 a.m. with LPN F revealed that she expected the staff to use the Kardex to know how to take care of the residents. The charge nurse or interdisciplinary team updated the resident's care plans as needed. The nurses were responsible for obtaining a physician's order for a resident's catheter care to change the T-sponge and assess the catheter insertion site. If the information was not included in the resident's care plan, the staff would have to ask a nurse, and then it could be updated. She expected the catheter type to be in the care plan since the type of care varies. She expected the order for the catheter cleaning to be in the resident's treatment administration record (TAR) for the nurses to complete. There was no documentation that resident 3's suprapubic foley catheter care was completed since his admission, as nothing was documented and the order was obtained on 8/26/26. Resident 6 was repositioned every two hours and when he requested additional assistance to change positions. He was able to reposition himself enough to have changes in circulation but would need one staff member to assist him to fully reposition off of his buttocks. The staff did not document when a resident was repositioned. She expected wounds, pressure-relieving cushions, continence, incontinence, and incontinent products used to be on the kardex. Specific wound cares were documented on the TAR. 9. Interview on 8/27/26 at 12:30 p.m. with DON B revealed she expected the staff to use the Kardex. She said, "Everything they need to know is in the Kardex." The nursing staff and management team updated the care plans. She said that if there was no individual information to the resident, she would	F0657		

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F0657 SS = D	Continued from page 25 expect the CNAs to use the standard of care they learn in CNA training and their education to care for the resident. She would expect the care plan to identify the specific catheter type used by the residents, as they require different care. She said the standard of care is that the residents within the facility are repositioned every two hours, but the staff do not document when that is completed. She would expect generalized wound information, the cushions used to offload residents, repositioning, catheter cleaning, and skin concerns to be in the residents' care plan. Specific wound treatments would be on the TAR. Interview on 8/27/26 at 12:30 p.m. with director of nursing (DON) B revealed she expected the staff to use the Kardex. She said, “Everything they need to know is in the Kardex.” The nursing staff and management team updated the care plans. She said that if there was no information individualized to the resident, she expected the CNAs to use the standard of care they learned in the CNA training and their education to care for the resident. She expected the care plan to identify the specific catheter type used by the residents, as they require different care. She said the standard of care was that the residents within the facility were repositioned every two hours, but the staff did not document when that was completed. She expected generalized wound information, the cushions used to offload residents, repositioning, catheter cleaning, and skin concerns to be in the residents' care plan. Specific wound treatments were documented on the resident’s TAR. 10. Review of the provider’s 1/9/26 Policy 8.1 Evaluations, Re-Evaluations, and Plan of Care policy revealed “Scope of evaluations include case history, prior level of function, determination of medical necessity, onset of functional decline, as well as contraindications and precautions. Clinicians will determine and implement a plan of treatment consistent with current best practices in the field of rehabilitation, in collaboration with the patient and family. This should be documented in the plan of care.” 11. Review of the provider’s October 2025 CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument, a standardized tool used in long-term care to evaluate residents’ strengths, needs, and overall status) version 3.0 Manual Chapter 4 CAA (Care Area Assessment) Process and Care Planning policy revealed “the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe	F0657		

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F0657 SS = D	Continued from page 26 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care."	F0657		
F0732 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.	F0732	1. Corrective Action for Residents Affected A. No residents were identified as being negatively affected by the deficient practice. B. The required staffing information was immediately updated and posted in the designated area accessible to residents, families, visitors, and staff. 2. Identification of Other Residents at Risk A. All residents have the potential to be affected by the facility's failure to maintain accurate staffing postings. No additional residents were identified as adversely affected. 3. Systemic Changes A: The Charge Nurses and IDT were reeducated on facility policy and regulatory requirements regarding staffing information postings. Education included the requirement to ensure staffing information is accurately completed, updated timely, and posted in the designated location accessible to residents, staff, families, and visitors. B: A process was implemented to verify the staffing posting is maintained daily and remains current. 4. Monitoring A. The Administrator or designee will audit the staffing posting 3-5 times weekly for 4 weeks and weekly for 8 weeks thereafter to ensure required staffing information is posted accurately and timely. Any concerns identified will be corrected immediately. B. Audit results will be reviewed during the QAPI meeting process. Additional education and corrective action will be implemented as needed to ensure ongoing compliance.	10/09/2026

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F0732 SS = D	Continued from page 27 (B) In a prominent place readily accessible to residents, staff, and visitors. §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 observations and interviews, the provider failed to ensure that the daily posted nurse staffing information was updated each shift to reflect the current date. Findings included: Observation on 8/25/26 at 1:57 p.m. showed that the posted daily nurse staffing sheet at the South nursing station displayed the previous day's date, 8/24/26. Observation on 8/25/26 at 4:14 p.m. showed the posted staffing sheet updated to 8/25/26. Observations on 8/26/26 at 9:41 a.m. showed that the same staffing sheet from 8/25/26 remained posted and was not updated at the beginning of the shift. Observation on 8/27/26 at 11:43 a.m. showed that the same staffing sheet from 8/25/26 remained posted and was not updated at the beginning of the shift. Interview on 8/25/26 at 2:01 p.m. with registered nurse (RN) E stated that the night shift nurse was responsible for completing and posting the staffing sheet for the following day and that business office manager (BOM) G updated the sheet when schedule changes occurred. Interview on 8/25/26 at 2:06 p.m. with BOM G confirmed that the night shift nurse was responsible for updating and posting the staffing sheet. Interview on 8/27/26 at 11:46 a.m. with licensed practical nurse (LPN) F stated that the night shift	F0732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0732 SS = D	Continued from page 28 staff posted the staffing sheet for the next day. The Daily Nurse staff posting policy was requested on 8/27/26, and it was not provided by the end of the survey.	F0732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2026

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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 8/25/26. Prairie View Healthcare Center 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
Kayla Evans	Administrator	9/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PRAIRIE VI... B. WING	(X3) DATE SURVEY COMPLETED 08/25/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/25/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Prairie View Healthcare 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.	K0000	1. Corrective Action for Residents Affected A. Resident #29 was interviewed regarding meal service concerns and satisfaction with food temperatures. Meal service processes were reviewed with dietary staff to ensure prompt tray delivery and temperature monitoring. B. Resident #42's concern regarding burnt pancakes was addressed immediately. Dietary staff were educated that food products that are burned, unpalatable, or do not meet quality standards are not to be served. C. All food implicated during the survey, including improperly thawed chicken, was immediately discarded. Safe food handling and thawing procedures were reimplemented. D. Food temperature monitoring was initiated for all hot foods prior to service and during tray line service to ensure food is served within acceptable temperature ranges. (Continued on next page)	10/09/2026
K0712 SS = D Bldg. 01	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 STANDARD 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 procedure (closing corridor doors). Findings include: 1. Observation on 8/25/26 beginning at 3:12 p.m. revealed a drill for a simulated fire in room 106 was being conducted. Further observation at that same time revealed the certified nursing assistant (CNA) responding to the activated nurse call light needed prompting to initiate the response to the simulated fire. The maintenance director running the fire drill	K0712		

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
Kayla Evans	Administrator	9/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - PRAIRIE VI...** B. WING	(X3) DATE SURVEY COMPLETED **08/25/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0712 SS = D Bldg. 01	Continued from page 1 had to walk the responding CNA through parts of the R.A.C.E. (Rescue, Alarm, Confine/Contain, and Evacuate) steps prior to the CNA taking any action. That CNA had to be further prompted by the maintenance director as to where a manual fire alarm pull station was, as well as how and what to page on the building's public announcement system. Through this process the door to room 106 was never closed to confine the effects of the simulated fire. Interview with the maintenance director immediately after the fire drill confirmed the findings that the CNA responding did not follow all the provider's fire drill procedures. He also stated he believed they did not pass the drill.	K0712	2. Identification of Other Residents at Risk A. All residents receiving meals from the dietary department had the potential to be affected by the deficient practice. An audit of dietary operations, meal temperatures, tray line procedures, food presentation, and food preparation practices was completed for all meal services. 3. Systemic Changes A. All dietary staff, cooks, and dietary supervisors were educated on: Safe food temperatures, proper hot and cold holding procedures, proper thawing procedures, food presentation and portion control standards, following standardized recipes and menus and requirements for serving palatable food free from burning, overcooking and poor appearance. B. Temperature logs were revised to include: final tray temperatures and corrective actions when temperatures fall outside acceptable ranges. C. A meal tray audit process was implemented to evaluate: food appearance, portion size, temperature and resident satisfaction. D.The Regional Dietitian or designee will review dietary staffing competency and ensure ongoing supervision of meal preparation and service activities. 4. Monitoring The Administrator, Dietary Manager/designee,	

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
	10714	A. BUILDING: _____ B. WING _____	08/27/2026

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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 8/25/26 through 8/27/26. Prairie View Healthcare Center was found not in compliance with the following requirements: S195 and S296.	S 000	1. Corrective Action for Residents Affected A. Resident #29 was interviewed regarding meal service concerns and satisfaction with food temperatures. Meal service processes were reviewed with dietary staff to ensure prompt tray delivery and temperature monitoring. B. Resident #42's concern regarding burnt pancakes was addressed immediately. Dietary staff were educated that food products that are burned, unpalatable, or do not meet quality standards are not to be served. C. All food implicated during the survey, including improperly thawed chicken, was immediately discarded. Safe food handling and thawing procedures were reimplemented. D. Food temperature monitoring was initiated for all hot foods prior to service and during tray line service to ensure food is served within acceptable temperature ranges. (Continued on next page)	10/9/2026
S 195	44:73:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain and operate in a manner to avoid undue danger to the safety of its occupants in one randomly observed location (south wing original building/100 wing). Findings include: Observation and Interview on 8/25/26 at 3:01 p.m. revealed the carpet on the floor entering the 100 wing (outside room 101) had what appeared to be duct tape on it. Further observation at that same time revealed one of the strips of tape was starting to come up from the carpet. That tape could catch an occupant's foot or the leg of a walker and was a trip hazard. Interview with the administrator and the	S 195		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kayla Evans | Administrator | 9/18/2026

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S 195	Continued From page 1 maintenance director at that same time revealed they were aware of the tape on the carpet, and they both agreed it was a trip hazard.	S 195	2. Identification of Other Residents at Risk A. All residents receiving meals from the dietary department had the potential to be affected by the deficient practice. An audit of dietary operations, meal temperatures, tray line procedures, food presentation, and food preparation practices was completed for all meal services. 3. Systemic Changes A. All dietary staff, cooks, and dietary supervisors were educated on: Safe food temperatures, proper hot and cold holding procedures, proper thawing procedures, food presentation and portion control standards, following standardized recipes and menus and requirements for serving palatable food free from burning, overcooking and poor appearance. B. Temperature logs were revised to include: final tray temperatures and corrective actions when temperatures fall outside acceptable ranges. C. A meal tray audit process was implemented to evaluate: food appearance, portion size, temperature and resident satisfaction. D.The Regional Dietitian or designee will review dietary staffing competency and ensure ongoing supervision of meal preparation and service activities. 4. Monitoring The Administrator, Dietary Manager/designee, or Regional Dietitian will perform: A. Meal observations three-five times per week for four weeks, then weekly	10/9/2026
S 296	44:73:07:11 Director of Dietetic Services A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination.	S 296		

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S 296	Continued From page 2 The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and observation, the provider failed to have a certified dietary manager (CDM) in the facility to oversee the dietary department and have aServSafe (a nationally recognized food and beverage safety training and certification program developed and administered by the National Restaurant Association) staff member within the facility. Findings include: 1. Interview on 8/25/26 at 8:15 a.m. with business office manager (BOM) G revealed they did not have any ServSafe staff members in the building, and the CDM left the facility's employment two weeks ago. 2. Observation on 8/25/26 at 4:00 p.m. revealed the requested facility information form from the Department of Health surveyors was not completed for the ServSafe certifications, as the facility reported to the survey team they did not	S 296	1.Corrective Action for Affected Areas A. The kitchen was immediately deep cleaned including: floors, dish washing area, clean storage areas, steam table area, equipment surfaces, plate warmer drawers, ventilation surfaces, clean dish storage, utensil containers B. All expired, uncovered, improperly stored, damaged, or potentially contaminated food items were discarded. C. The damaged skillet with peeling coating was removed from service and discarded. D. Improperly thawed chicken identified during survey was discarded immediately. 2. Identification of Other Residents at Risk A. All residents receiving meals or snacks from the dietary department had the potential to be affected by the deficient practice. A facility-wide review of food storage, sanitation, food preparation, dietary equipment, and food safety practices was completed. 3. Systemic Changes A. All dietary personnel received education and regarding: safe food handling, safe thawing procedures, food storage requirements, labeling and dating requirements, cleaning and sanitation expectations, prevention of cross-contamination and hand hygiene and glove use B. A comprehensive dietary sanitation checklist was implemented requiring daily documentation of: floors, equipment, shelving, dish washing area, refrigerators and freezers and food storage areas C. Temperature monitoring logs were revised	

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S 296	Continued From page 3 have any certified staff in the facility. 3.Interview on 8/26/26 at 9:07 a.m. with administrator A revealed she was aware the kitchen was struggling to maintain standards of the facility and her expectations. She was aware the facility did not have anyone with a ServSafe certification. 4. Interview on 8/27/26 at 11:35 a.m. with regional dietician R revealed that she visited the facility every 3 months. She was aware there were no certified ServSafe staff members in the building but knew there should be at least one in the kitchen or available within the facility. The risk of not having a ServSafe staff member in the building was that the staff who were not certified did not understand proper food preparation and the process of all ServSafe techniques. There was currently no process for when a ServSafe staff member was not present in the facility. She expected someone in the facility to oversee the kitchen when she was not present. 5. The provider did not have a ServSafe policy.	S 296		