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
	11087	A. BUILDING: _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PRAIRIE MANOR	1145 GOLDEN PRAIRIE DR POST OFFICE BOX 400 WINNER, SD 57580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 02/20/24 through 02/22/24. Golden Prairie Manor was found not in compliance with the following requirements: S200, S201, S215, S315, S320, S331, S337, S352, S443, S450, S478, S489, S506, S670, and S685.	S 000	A 1 & 2	
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation, testing, and interview, the provider failed to maintain all smoke barriers to resist the passage of smoke (in the 100 and 200 wings). Findings include: 1. Observation and testing on 2/21/24 at 11:07 a.m. revealed the pair of smoke barrier doors at the east end of the 100 wing would close when released from the magnetic hold opens on the wall. That pair of doors had become warped and left a gap at the top greater than the allowable one-eighth inch when closed. That gap did not	S 200	To keep residents & staff safe in the event of a fire, the smoke barrier doors at the east end of the 100 wing and the east end of the 200 wing of the facility will be equipped with a rubber/ brush gasket which will allow the doors to come together to attain the one-eighth inch spacing permitted when closed. During the monthly fire drills, it will be the responsibility of maintenance (administration in the absence of maintenance) to check the seals of the doors to ensure compliance. This will be an ongoing task which will be added to the monthly maintenance checklist and reviewed by administration on a monthly basis. The results of the observations will be reported to the Board of Directors at monthly board meetings.	4/7/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori McCarty	Administrator	3/16/2024

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S 200	Continued From page 1 meet the requirements for resisting the passage of smoke. Interview with maintenance director G at the time of the observation and testing confirmed that finding. 2. Observation and testing on 2/21/24 at 11:40 a.m. revealed the pair of smoke barrier doors at the east end of the 200 wing would close when released from the magnetic hold opens on the wall. That pair of doors had become warped and left a gap at the top greater than the allowable one-eighth inch when closed. That gap did not meet the requirements for resisting the passage of smoke. Interview with maintenance director G at the time of the observation and testing confirmed that finding. B. Based on observation, testing, and interview the provider failed to furnish continuously illuminated exit signs at four randomly observed locations (west end of the 200 wing, east end of the 200 wing, north of the 200 wing nurse's station, and the south exit door of the 300 wing). Findings include: 1. Observation and testing on 2/21/24 at 12:12 p.m. revealed the exit sign at the west end of the 200 wing was operating but would not function when the battery back-up circuit was activated. That exit sign would not provide continuous illumination for egress in the event of a power failure. Interview with maintenance director G at the time of the observation and testing confirmed that finding.	S 200	B 1 - 3 To ensure all exit signs are operating and operating on battery backup, the administration will map out the locations of all exit signs in the facility. Once completed it will be the task of maintenance to check each exit sign to make sure it is a) working correctly, and b) test it to ensure the battery backup works as well. Any light that is not in working condition will be fixed within 24 hours and reported to administration. This task will be added to the monthly maintenance checklist and will be reviewed by the administrator on a monthly basis. This will be an	

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S 200	Continued From page 2 2. Observation and testing on 2/21/24 at 12:15 p.m. revealed the exit sign at the east end of the 200 wing was operating but would not function when the battery back-up circuit was activated. That exit sign would not provide continuous illumination of signage for egress in the event of a power failure. Interview with maintenance director G at the time of the observation and testing confirmed that finding. 3. Observation and testing on 2/21/24 at 12:21 p.m. revealed the exit sign north of the 200 wing nurse station was not operating and would not function when the battery back-up circuit was activated. That exit sign would not provide continuous illumination of signage for egress in the event of a power failure. Interview with maintenance director G at the time of the observation and testing confirmed that finding. 3. Observation and testing on 2/21/24 at 12:21 p.m. revealed the exit sign north of the 200 wing nurse's station was not operating and would not function when the battery back-up circuit was activated. That exit sign did not provide the required continuous illumination of signage for egress. Interview with the maintenance director G at the time of the observation and testing confirmed that finding. 4. Observation and testing on 2/21/24 at 12:36 p.m. revealed the exit sign on the door leaving the south end of the 300 wing was not externally	S 200	ongoing task with the results being reported to the Board of Directors at monthly board meetings. B 4 A photoluminescent (glow-in-the-dark)	4/7/2024

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S 200	Continued From page 3 lit, internally lit or photoluminescent. That exit sign did not provide the required continuous illumination of exit signage for egress. Interview with maintenance director G at the time of the observation and testing confirmed that finding.	S 200	exit sign will be hung in such a way that anybody using this exit will be able to clearly identify a safe passage out of the facility. This ongoing task will be added to the maintenance weekly schedule and will be reviewed weekly by the administrator. Findings of this report will be reviewed by the administrator and a report will be presented to the Board of Directors at monthly board meetings.	
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of 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 record review and interview the provider failed to conduct the required amount of fire drills for the building in the twelve-month period preceding the survey (February 2023 through January 2024). Findings include: 1. Record review on 2/21/24 at 1:05 p.m. revealed there was no documentation of fire drills being conducted quarterly for each shift for the twelve-month period preceding the survey. Interview with administrator A that same day at 1:13 p.m. confirmed that finding. She stated she had gotten out of the habit of conducting monthly drills during the COVID-19 pandemic and wasn't	S 201	To ensure the safety of the residents, staff, visitors, and families, monthly fire drills will be conducted to ensure all parties know what to do in the event of a fire. The administrator will be responsible for conducting the fire drill according to SD state regulations. As a reminder, the administrator will schedule the fire drills, add them to the calendar, and immediately after the drill, document the drill and its outcome. Fire drill information will be discussed at monthly staff meetings. This ongoing task will be the	4/7/2024

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S 201	Continued From page 4 back on track. The deficiency had the potential to affect 100% of the building occupants.	S 201	responsibility of the administrator and will be reported to the Board of Directors at monthly board meetings.	4/7/2024
S 215	44:70:03:03 Fire Extinguisher Equipment Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, and interview, the provider failed to ensure all fire extinguishers received the required inspections for the twelve-month period preceding the survey (February 2023 through January 2024). Findings include: 1. Observation beginning on 2/21/24 at 11:00 a.m. revealed the fire extinguisher in the activities office had not received any inspection for the	S 215	The safety of residents, staff, and visitors is a primary concern for the facility. To see that we are able to provide this safety, the location of fire extinguishers will be mapped out and a corresponding checklist will be created by the administrator. The proper way to inspect a fire extinguisher will be presented to all staff at the March 2024 staff meeting. They will be informed as to the locations of the fire extinguishers and the checklist. To ensure that all extinguishers are inspected, the administrator will designate a day each month for the task to be completed and will assign the task to a staff member for completion. This aspect will allow all staff to know where fire extinguishers are located in the facility. This ongoing task will be monitored on a monthly basis by the facility administrator and will be reported to the Board of Directors at the monthly board meeting.	4/7/2024

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S 215	Continued From page 5 previous month (January 2024). Further observation that same day at 12:12 p.m. revealed the same condition existed for two other fire extinguishers (in the laundry and maintenance). Record review on that same day at 12:52 p.m. revealed the fire extinguisher tags kept as record from the previous years did not have records of the extinguishers being checked monthly as required. The deficiency had the potential to affect 100% of the building occupants. Interview with maintenance director G at the same time of the observations confirmed those conditions.	S 215		
S 315	44:70:04:07 Prevention And Control Of Influenza Each facility shall arrange for an influenza vaccination to be completed annually for each resident. Each resident shall be offered influenza vaccine when the resident is admitted and annually during the influenza season. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure three of three sampled residents (1, 2 and 3) received an annual influenza vaccine, received or declined an annual influenza vaccination. Findings include: 1. Review of care records for residents 1, 2, and 3 revealed the following: *Resident 1's admission date was 9/8/22.	S 315	Resident health is important to keep residents and staff safe when living in a facility. To help achieve this, a form will be added to the admission packet explaining the benefits of influenza vaccines and given the choice to receive the vaccine upon admission or refuse the vaccine. This form will be given to the facility RN for follow-up. Annually, a vaccination clinic will be scheduled by the facility RN to take place at the facility. The facility RN will ensure that all residents who are able to make the decision on their own, as well as the primary family member for those who cannot, are informed of the vaccination clinic, choose to participate or refuse, and fill out the corresponding paperwork for the clinic. A copy of this paperwork will be given to the resident's primary care	

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S 315	Continued From page 6 -Her last recorded influenza vaccination was 10/7/22. *Resident 2's admission date was 9/29/23. -There was no recorded influenza vaccination given or declined. *Resident 3's admission date was 11/1/18. -Her last recorded influenza vaccination was 10/7/22. *There was no documentation to support resident 1, 2 or 3 had received or declined the influenza vaccine. Interview on 2/22/24 at 12:43 p.m. with administrator A regarding the influenza vaccination of residents revealed she: *Confirmed the influenza vaccine had not been offered to the residents. *Thought residents 1, 2, and 3 had their influenza vaccinations provided at their individual providers' clinic. *Confirmed there was no documentation to support those three residents had received or declined the 2023 influenza vaccination. Director of nursing B was not available for an interview.	S 315	provider and the original will be placed in the resident's file located in the nurse's office. If a resident receives a vaccination other than at the facility, documentation from the provider will be requested and placed in the resident's file. The administrator will follow-up with the RN to make sure the vaccination clinic is scheduled, paperwork is completed, and vaccinations are given. This ongoing task will be monitored by the facility RN and Administrator upon admission to the facility and annually. Reports to the Board of Directors will be given at monthly board meetings.	4/7/2024
S 320	44:70:08 Prevention And Control Of Pneumonia Each facility shall arrange for an immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage a resident to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded in the resident's care record.	S 320		

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S 320	Continued From page 7 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure two of three (1 and 2) sampled residents had received the pneumococcal vaccine, received or declined the vaccination to be administered at a different location within 14 days of admission. Findings include: 1. Review of resident 1 and 2's care records revealed the following: *Resident 1's admission date was 9/8/22. *Resident 2's admission date was 9/29/23. *There was no documentation to support resident 1 or 2 had received or declined the pneumococcal vaccine. Interview on 2/22/24 at 12:43 p.m. with administrator A regarding the pneumococcal vaccination of residents revealed: *She confirmed there was no documentation to support resident 1 or 2 had received or declined the pneumococcal pneumonia vaccine. -She would have to call the resident's providers to determine if either of the above residents had received the vaccine. Director of nursing B was not available for an interview.	S 320	Resident health is important to keep residents and staff safe when living in a facility. To help achieve this, a form will be added to the admission packet explaining the benefits of Pneumonia vaccines and given the choice to receive the vaccine upon admission or refuse the vaccine. This form will be given to the facility RN for follow up. The facility RN will ensure that the resident's primary care physician is aware of the resident's decision to receive the pneumococcal pneumonia vaccine or decline it. The RN will obtain proper documentation from the resident's PCP for either decision, and that documentation will be placed in the resident's file located in the RN's office. The administrator will follow-up with the RN on all new admissions to make sure proper vaccinations have been received or documentation of refusal is on file. This ongoing task will be reported as needed to the Board of Directors at monthly Board meetings.	
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment	S 331		4/7/2024

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S 331	Continued From page 8 that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of four recently hired sampled employees (D and E) had received the two-step tuberculin (TB) skin test within twenty-one days of employment. Findings include:	S 331	To maintain the health and safety of the occupants of the facility, TB skin tests will be conducted upon hiring of new employees and admission of new residents unless proper documentation has been provided from a previous healthcare provider within correct time-frames. The administrator will be responsible for obtaining proper documentation if a new employee has come from another facility where they received the TB test or documentation of a positive reaction to the test. If the new employee requires a TB test, the administrator will contact the RN prior to putting the new employee on the schedule so the TB test can be given within the correct parameters of starting. This will be documented on the new Employee Checklist form created by the administrator. If an employee fails to comply with the TB testing guidelines or does not come in for the TB test, that employee will not be put on the schedule until testing is complete. The administrator will be responsible for following up with the RN to ensure the TB test is completed and all documentation is filed. These findings will be reported as needed to the Board of Directors at the monthly board meetings.	4/7/2024

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S 331	Continued From page 9 1. Review of employee D's personnel record revealed: *She was hired on 9/2/23. *There as no documentation of the administration of a TB skin test. Review of employee E's personnel record revealed: *She was hired on 3/9/23. *There as no documentation of the administration of a TB skin test. Interview on 2/22/24 at 11:04 a.m. with administrator A regarding TB skin tests revealed: *Director of nursing (DON) B was responsible to administer and record employee TB skin tests. *Administrator A would review the record for completion of the TB skin tests before filing the form in the employee's personnel file. *She confirmed employees D and E had no TB skin test documentation. DON B was not available for an interview.	S 331		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, employee training record review, interview, job description review, and policy review, the provider failed to ensure: *One of one observed unlicensed assistive personnel (UAP) (H) primed the insulin pen prior	S 337	Employee training is an integral part of a facilities ability to provide the proper care to residents entrusted to our facility. The facility RN will be responsible for the initial UAP training of all newly-hired UAP's prior to them being placed on the schedule, and the RN will be responsible for the scheduling and presentation of the annual UAP training for all facility UAP's. The RN and administration will meet to discuss the training dates to make sure they	

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S 337	Continued From page 10 to having the resident administer their insulin injection. *One of one UAP (H) had received unlicensed diabetic aide (UDA) training before assisting resident 2 with her insulin pen administration. Finding include: 1. Observation and interview on 2/21/24 at 11:17 a.m. with UAP H during resident 2's medication administration: *UAP H obtained an insulin pen from the medication cart. -Delivered the insulin pen to resident 2 to self-administer the insulin. --UAP H did not prime the insulin pen before giving resident 2 the insulin pen. --Resident 2 did not prime the insulin pen before self-administering the insulin. *UAP H stated the only time insulin pens were primed was when a new pen was opened and before its first use. Review of employee H's training records revealed she was hired on 4/17/23 and did not have UDA training completed related to insulin administration. Interview on 2/22/24 at 8:45 a.m. with director of nursing B regarding priming of the insulin pens revealed: *They were only primed when a new pen was opened for resident use. *UDA training had not been provided to UAP H. *She was aware of the requirement for UDA training for UAPs who assisted with insulin administration. *She was responsible for ensuring the training occurred. *She had not made arrangements for the training to occur.	S 337	will be within the proper timeframe of the UAP's hire dates. Training as well as the review of medication assistance policies and procedures will be an ongoing process. The facility RN will also be responsible for keeping up to date on any new training requirements that may be needed for the UAP's. Policies and Procedures were updated including Med-Aides Administering Insulin and Priming and Storage of Insulin Pens. These polices are being reviewed with the UAP's during the UDA training module that facility UAP's are currently taking. The facility RN will be responsible for updating policies pertaining to medication assistance as well as training UAP's. The RN will report to the administrator as well as to the Board of Directors at the monthly board meetings.	4/7/2024

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S 337	Continued From page 11 Interview on 2/22/24 at 9:18 a.m. with administrator A regarding UDA training revealed: *She was aware of the requirement for UDA training for UAPs who assisted with insulin administration. -She had reviewed what was necessary to complete the UDA training. *There was no UDA training scheduled for the UAPs. Review of the provider's undated Unlicensed Assistive Personnel (UAP) job description revealed: *"8. (UAP) Medication Assistance: Employee is required to successfully complete the state approved UAP course before passing medications. In addition to the above listed duties, UAP is responsible to perform the following duties as well as any other assigned duties: -Administer medications, document administration of medications, and monitor medication supplies. -Perform vital checks when scheduled and document." *The policy did not include UDA education. Review of the provider's undated Priming and Storage of Insulin Pens policy revealed: *"It is the policy of Golden Prairie Manor to follow manufacturer's recommendations as to priming and storage of insulin pens. It is acceptable for Medication aides to prime the insulin pens for residents ..." *"Priming Insulin Pens: -1. Prime the pen before each injection. This releases a small amount of insulin into the pen to help get rid of air bubbles that may be in the pen. Air bubbles can affect the flow of insulin and	S 337	3/28/2024 - The facility RN will be responsible for training the UAP's when there is a change in policies and procedures. The RN will also provide this training to the UAP's annually in June to coincide with the facility's annual in-service for all staff. Training will occur whenever there is a change in a current policy and procedure or when a new policy and procedure is introduced. A binder with medication assistance policies and procedures will be kept in the RN's office. A table of contents listing the name of the policy and date added to the binder will be placed at the front of the binder. A spreadsheet of UAP names and training dates will also be included. Upon completion of a training module, the RN will ensure that the UAP signs and dates the spreadsheet. The RN will inform the administrator when all UAP's have completed the training. This will be an ongoing facility practice. The RN will report to the Board of Directors at monthly board meetings. *LM*	

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	11087	A. BUILDING: _____ B. WING _____	02/22/2024

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S 337	Continued From page 12 cause you inject the wrong amount." -"3. Dial the number of units of insulin on the dose selector ordered by the physician. For most insulin pens, you will hear a click for each unit of insulin that you have dialed. Point the needle up. Firmly press the plunger until a drop of insulin appears at the needle tip. Repeat this step if a droplet does not appear. You may need to use a different needle or pen if you have to repeat this step several times."	S 337		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to evaluate and document the care needs for the following: *One of three sampled residents (1) annually. *One of three sampled residents (2) thirty days after their admission. Findings include: 1. Review of resident 1's care record revealed: *She was admitted on 9/8/22. *Her initial evaluation of care needs was completed on 8/31/22. *Her thirty day evaluation of care needs was completed on 10/7/22. *There was no documentation to support her annual evaluation of care needs was completed.	S 352	Our facility stives to provide the best possible care that we can give to our residents depending on their needs. This can only be achieved through the continuous monitoring of the residents and their activities. The facility RN has implemented a new Assisted Admission Check-off List to use as a guideline when admitting a new resident to the facility. The current form used by the RN for the evaluation of the resident has also been updated to reflect these changes. The facility RN and the administrator will review this form within one week of the initial admission to the facility to see that all admission requirements have been met by both the resident and the facility. The administrator has created a form to help keep track of resident evaluation dates as well as the annual wellness check which will be used	

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S 352	Continued From page 13 2. Review of resident 2's care record revealed: *She was admitted on 9/29/23. *Her initial evaluation of care needs was completed on 9/19/23. *There was no documentation to support her thirty-day evaluation of care needs was completed. 3. Interview on 2/22/24 at 12:46 p.m. with administrator A revealed: *Director of nursing (DON) B was responsible for completing the residents' evaluations of care needs for residents upon admission or before admission, at 30 days after admission, and annually. *She confirmed there was no documentation to support the following: -Resident 1's annual evaluation of care needs was completed. -Resident 2's thirty-day evaluation of care needs was completed. DON B was not available for an interview.	S 352	to assist the RN with evaluation needs. This form will be kept in a binder in the administrator's office. This ongoing process will be reported to the Board of Directors at the monthly board meetings. 3/28/2024 - This form will be kept in a binder in the administrator's office and will be reviewed by the administrator and the RN during the first week of every month and upon admission or discharge of an assisted living resident. *LM*	4/7/2024
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to ensure one of three sampled residents (1) had received an annual cognitive screening. Findings include:	S 443	Elderly residents' needs can change daily, making it important to know your residents and how they function. An annual cognitive screening is useful in determining if a resident's needs are being met or if changes need to be made to a resident's care plan. The facility RN will perform an annual cognitive screening on each resident to ensure that their care needs are being met. The form created by the administrator for evaluation dates and	

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S 443	Continued From page 14 1. Review of resident 1's care record revealed: *She was admitted on 9/2/22. *There was no documention to support a cognitive screening was completed annually. Interview on 2/22/24 at 12:49 p.m. with administrator A revealed: *Director of nursing (DON) B was responsible to ensure resident's cognitive screenings were completed on admission, 30 days after admission, and annually. *She confirmed there was no documentation to support a cognitive screening was completed annually for resident 1. DON B was not available for an interview.	S 443	annual assessments will be used to assist the RN in making sure the resident is being evaluated upon admission, 30 days after admission, and annually. This form will be kept in a binder in the administrator's office. The results of this ongoing process will be presented to the Board of Directors at the monthly board meetings. 3/28/2024 - This form will be reviewed by the administrator and RN during the first week of very month or upon a change of condition. All staff are made aware of what constitutes a change of condition at the annual in-service and upon hire. Monitoring of residents is done on a daily basis by all staff. *LM*	4/7/2024
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain a safe and sanitary food service environment related to cleanliness, food storage, and the dating of packaged food in one of one kitchen. Findings include: 1. Observation on 2/21/24 at 11:40 a.m. of the kitchen revealed: *In the dishwashing area there were the following:	S 450	A safe and sanitary food prep area is imperative in the prevention of food-borne illness, especially in the elderly. The facility's dietary department has had turnover and staff who do not realize the importance of keeping the food prep area clean. Going forward, training will be an integral part of the dietary area. The administrator will be responsible for training staff and assigning cleaning duties in the kitchen to employees. A new cleaning checklist will be developed by the administrator focusing on areas that need to be thoroughly cleaned.	

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S 450	Continued From page 15 -A fan blowing on the clean dishes. -Alight fixture above the dishwashing machine was covered in what appeared to be a one-half inch thick layer of dust. -The walls surrounding the dishwasher had numerous areas that appeared to have been covered in dust. -A dishwasher that had lime build-up and crumbs from an unknown substance on the top of the machine. *The refrigerator had contained leftovers stored in used yogurt, whipped topping, sour cream, cottage cheese, and plastic Christmas one-time use containers. *A second refrigerator contained the following: -An orange cup with a lid and an unknown substance in it. -A resident's coffee creamer and pop. *The dry storage area had the following: -Five plastic Cambro containers labeled as pasta with no open or expiration dates on them. -A whipped topping one-time-use container with a white thick substance in it. -A whipped topping one-time-use container with a brown thick substance and a plastic spoon in it. -Two plastic packages of what appeared to be dry cereal, with no label and no open or expiration dates on them. *The freezer had a one-time-use cup with a frozen brown substance and a straw in it. *A dry storage cupboard contained the following items: -A box of Minute Rice that was opened, not sealed, and no opened date. -A box of Hungry Jack mashed potatoes, that was opened, not sealed, and no opened date. -Two plastic Cambro containers, both with an unknown white substance in them, with no opened date.	S 450	-The fan has been removed from the dishwasher area. -The light fixture and walls are being addressed for cleaning. -The chemical company who installed the dishwasher has been contacted about deliming the dishwasher. -New food-safe containers have been ordered. All plastic one-time use containers will be disposed of. -Food belonging to staff members will need to be labeled and placed in the staff refrigerator at the nurse's station. -Pasta labels will be printed and open and expiration date areas will be placed on the containers. -Staff have been reminded not to place their personal items in the pantry area. -Containers for dry cereal have been ordered. They will be labeled with name, open date, and expiration. -Staff have been asked not to place their food in the freezer. -Large gallon and two gallon ziploc bags have been ordered for any boxed food that is opened. They will be labeled with name, open date, and expiration. -Labels for the sugar and powdered sugar containers will be made with open and expiration dates on them.	

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S 450	Continued From page 16 Observation on 2/21/24 at 12:30 p.m. in the kitchen of the February 2024 posted cleaning schedules revealed there were places to record cleaning of various items in the kitchen for each day (Monday through Saturday), that had not been signed off from 2/1/24 through 2/21/24 as completed. Observation on 2/21/24 at 12:40 p.m. of the dining room revealed an ice-dispensing machine that had lime build-up in the areas that dispensed the ice and water. Interview on 2/21/24 at 12:45 with administrator A revealed she: *Was responsible for the operations of the dietary department. *Was ServSafe certified. *Agreed with the above findings. *Thought the one-time use containers of yogurt, whipped topping, sour cream, cottage cheese, and plastic Christmas were appropriate to use for left-overs. -Thought the whipped cream containers in the dry storage area contained caramel sauce and cream cheese frosting from 2/20/24. -She was not sure how long those items could have been stored at room temperature. *Was not sure the last time the dishwasher or ice-dispensing machine had been cleaned. *She confirmed the kitchen should have been maintained in a clean and sanitary condition and that the cleaning checklist should have been followed. Review of the provider's undated Leftover Food Handling policy revealed: *"1. All leftover food must be handled according to dietetic guidelines for storing and reheating." *"2. Food stored within the refrigerator or freezer	S 450	-The 'Clean as you Go' sheets will be reviewed with staff at the upcoming March staff meeting. They will be updated and expectations will be set as to the completion of these daily tasks. The company where the ice machine was purchased has been contacted to determine if they can provide assistance in cleaning the lime build-up and properly training staff to maintain the machine to prevent this from happening. The Leftover Food Handling Policy as well as the Sanitation and Infection Control Food Service Policy will be reviewed with all staff at the March staff meeting. With all staff helping in the dietary department in one form or another, an overview of the kitchen and the dietary training binder will be gone over at the March staff meeting. Those who work solely in the kitchen area will be the front line in reporting to the administrator if they find something that needs to be cleaned, changed, or ideas for completing a task differently. The administrator will do a daily walk-through of the kitchen area to ensure that the dietary department is coming into compliance.	

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S 450	Continued From page 17 must meet all of the criteria identified below: -a. it is within date. -b. all unnecessary outer packaging is removed. -c. it is kept in a clean, airtight container or impervious wrapping. -d. it is labeled with the name of the item and the date that it was put in the refrigerator (use masking tape and a permanent marker) -e. it is for human consumption." *"4. All other leftovers placed in the refrigerator may be used for consumption within 72 hours. It not used within the time frame, the cook will dispose of the leftover food using the garbage disposal." Review of the provider's undated Sanitation and Infection Control Food Service policy revealed: *"It is the policy of Golden prairie Manor to take all precautions necessary to eliminate any change of contamination during preparation, service, or disposal of food, garbage, refuse and waste. *The Administrator will oversee all activities involved with the preparation, serving, storage of food, and disposal of waste to make sure all the following policies are followed:" -"2. Equipment in the food and service areas shall be cleaned and free of dust, grease, and dirt after each use." A policy for dishwasher cleaning and ice-dispensing machine cleaning was requested on 2/21/24 at 12:47 p.m. from administrator A and was not received by the end of the survey.	S 450	The administrator will write a policy on cleaning the dishwasher and adjacent area. The administrator will write a policy on cleaning the ice and water dispenser. The policies will be a part of the new hire training as well as the annual in-service. The administrator will be responsible for reporting the findings of this ongoing process to the Board of Directors at the monthly board meeting. 3/28/2024 - Once the policies for the cleaning of the dishwasher and ice and water dispenser are written, the administrator will review them with all staff during a morning and an afternoon special team huddle. The administrator will set up a time to meet with the overnight shift to review the policies. These meetings will take place within a week of approving the new policies and procedures. To maintain the highest level of cleanliness, the administrator will continue to do daily walk-throughs of the facility. *LM*.	4/7/2024
S 478	44:70:06:09 Written Menus A dietician shall annually approve, sign, and date each planned menu for all facilities except a facility without therapeutic diet services.	S 478		

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S 478	Continued From page 18 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interviews the provider failed to ensure registered dietitian (RD) F approved, signed, and dated the planned menus for 22 of 22 residents which included a therapeutic diet of consistent carbohydrate (CCHO) for one of one sampled resident. Findings include: 1. Review of resident 2's care record revealed: *Her diagnosis included diabetes. *She had a physician's order for a CCHO diet to help control her diabetes. Interview on 2/21/24 at 10:00 a.m. with administrator A during the entrance conference revealed: *The provider was licensed to provide physician ordered therapeutic diets. *Resident 2 was to have been provided a physician ordered CCHO diet. Interview on 2/22/24 at 12:43 p.m. with administrator A revealed: *She was responsible for the dietary services operations. *She thought that RD F had approved, signed, and dated the planned menus, including the CCHO diet extensions. -She was unable to find those approved, signed, and dated menus. *There was no documentation to support RD F had approved, signed and dated those menus.	S 478	Food service is an important asset to provide the proper nutrition to all residents of the facility. Menus are based on resident likes and dislikes, favorite recipes, and ethnicity in addition to nutritional values. The administrator will send the 5 week rotation of menus to the contracted registered dietician for her approval. The registered dietician will provide the CCHO diet extensions for those who require this diet. After approval, the administrator will ensure that the dietician has signed the menu as well as the dietary extensions and place a copy of both in the dietary binder in the kitchen. The original copy will be filed in the administrator's office. The menus will be reviewed and signed by the dietician on an annual basis. The administrator will be responsible for reporting this ongoing process to the Board of Directors at a monthly board meeting annually.	4/7/2024

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S 489	Continued From page 19	S 489		
S 489	44:70:06:12 Dietary Manual A therapeutic diet manual with a description of all diets served in the facility must be readily available in the facility to healthcare personnel. The manual must have been updated within the last five years. This Administrative Rule of South Dakota is not met as evidenced by: Based on the diet manual review and interview, the provider failed to ensure there was a current diet manual (updated within the last five years) available for staff use in the facility. Findings include: 1. Review of the two diet manuals located in the kitchen area revealed one was dated 1996 and the other dated 2014. Interview on 10/22/24 at 9:25 a.m. with administrator A regarding a current diet manual revealed she: *Was not aware the diet manual should have been updated. *Confirmed there was no current diet manual.	S 489	The dietary manual is readily available to the dietary department or any other personnel to aide them with facility therapeutic diets. A new dietary manual has been ordered for the facility. The administrator will put a reminder on the calendar to check for an updated dietary manual annually in March. New manuals will be ordered as needed. It will be the administrator's responsibility to report this annual check to the Board of Directors at the March board meeting annually.	4/7/2024
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety;	S 506	All staff members, regardless of their hired job duty, play some part in the dietary aspect of the facility. It is important that all staff know the food basics so residents can receive the continuity of care throughout the dining process. As part of the new hire packet, the dietary and food-handling services information will be provided to the	

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S 506	Continued From page 20 (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel record review, training records, and interview, the provider failed to ensure one of two recently hired sampled dishwashing employees (C) received the required dietary in-service training within 30 days of hire and annually. Findings include: 1. Dishwasher C was hired on 1/2/23 and there was no training documented within 30 days of hire or annually for the required dietary training topics. Interview on 2/22/24 at 11:06 a.m. with administrator A regarding dishwasher C's 30-day and annual training revealed: *Administrator A was responsible for ensuring the training was completed. *Dishwasher C had started in the dietary department, working limited hours in January 2023. *Administrator A thought employees that worked limited hours did not require 30-day and annual training. Review of the provider's undated Sanitation and	S 506	newly hired staff member. It will be the administrator's responsibility to make sure the new staff member receives the dietary training packet with their initial required paperwork. The administrator will review the training with the new staff member and answer questions they may have. Infection and Infection Control will be discussed at the March 2024 staff meeting. This will also be a topic at the annual in-service held in June. It will be the administrator's duty to report this aspect of training to the Board of Directors upon hire of a new employee and annually at in-service. This will be done at the corresponding monthly Board of Directors meeting.	4/7/2024

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S 506	Continued From page 21 Infection Control Food Service policy revealed: "16. The facility will provider education and orientation to all personnel on infection and infection control. This will be done upon orientation, annually at in-service training, or at any time Administration feels that it may be useful to staff."	S 506		
S 670	44:70:07:07 Medication Administration A registered nurse shall provide medication administration training pursuant to § 20:48:04.01 to any unlicensed assistive personnel employed by the facility who will be administering medications. Unlicensed assistive personnel shall receive initial and ongoing resident specific training for medication administration and annual training in all aspects of medication administration occurring at the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training record review, interview, and job description review, the provider failed to ensure: *Two of two sampled unlicensed assistive personnel (UAPs) E and H received initial training for administration of medications. *Four of four sampled UAPs (I, J, K, and L) received ongoing annual training for the administration of medications. Finding include: 1. Review of employee training records revealed: *Employee E was hired on 3/9/23. *Employee H was hired on 4/17/23. *There was no documentation to support the above UAPs had received initial UAP training.	S 670	To safely and properly care for the needs of the facility's residents, it is important for UAP's to know and understand what is expected of them as a UAP and receive continuing education in the ever-changing medical field. It is the responsibility of the facility RN to provide such training and to ensure that the UAP's are up to date with the latest medical information. The administrator will keep in contact on a weekly basis with the facility nurse to ensure that all UAP's continue to receive needed education. The administrator will also add ongoing training to the facility's UAP job description. The RN and administrator will work together to schedule all annual UAP training to be completed within one month's time frame to eliminate the possibility of a UAP being overlooked. The current new hire employee check-list will be updated to include initial UAP training by RN.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN PRAIRIE MANOR	1145 GOLDEN PRAIRIE DR POST OFFICE BOX 400 WINNER, SD 57580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 670	Continued From page 22 2. Review of employee training records revealed: *UAP I was hired on 6/7/22. *UAP J was hired on 10/15/19. *UAP K was hired on 2/22/12. *UAP L was hired on 6/25/19. *There was no documentation to support the above UAP's had ongoing annual medication administration training. Interview on 2/22/24 at 8:45 a.m. with director of nursing B regarding UAP training revealed: *She had not provided the required training to the following employees: E, H, I, J, K, and L. *She was aware of the requirement for initial and ongoing annual UAP training. *The Board of Nursing approved form was used when annual training was completed. *She was responsible for the UAP training. *She had not made arrangement for the training. Review of the provider's undated Unlicensed Assistive Personnel (UAP) job description revealed: *"8. (UAP) Medication Assistance: Employee is required to successfully complete the state approved UAP course before passing medications. In addition to the above listed duties, UAP is responsible to perform the following duties as well as any other assigned duties: -Administer medications, document administration of medications, and monitor medication supplies. -Perform vital checks when scheduled and document." *The job description did not include ongoing UAP education requirements.	S 670	The RN will report to the administrator when initial UAP and annual UAP training is completed. The administrator will report to the Board of Directors the completion of UAP training and the annual UAP training at the coinciding monthly board meeting. 3/28/2024 - The RN will use the SD BON checklist to ensure that all required training is reviewed with the UAP's. The RN will complete this checklist for any new hire UAP's during the first week of employment. The RN will use this checklist during the annual assessment of UAP's which will be conducted annually in October. *LM*	4/7/2024

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S 685	Continued From page 23	S 685		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and care record review, the provider failed to ensure one of one sampled resident (2): *Was assessed to determine her ability to self-administer medications. *Had a physician's order allowing her to self-administer her insulin. Findings include: 1. Observation and interview on 2/21/24 at 11:17 a.m. with unlicensed assistive personnel (UAP) H during medication administration for resident 2 revealed the resident: *Self-administered her physician-ordered Humalog insulin. *Had administered that insulin to herself since her admission.	S 685	Residents are encouraged to try to do things on their own to help them maintain independence and dignity. We understand that some residents are not able to complete certain tasks due to various factors which we are on the continuous lookout for. If a resident requests to keep their medications in their room, the RN will assess their ability to do so upon move in and throughout their stay at the facility. To ensure this is completed, the RN's initial assessment record, as well as the New Assisted Admission Check-off List has been updated to reflect Self-Administration of medications. Resident 2 did have a physician's order allowing her to self-administer medications. The RN and administrator will review this on new admissions to ensure that the physician has stated as such. The RN will be responsible for the assessment and then reporting the decision to the administrator. The administrator will report the findings of self-medication to the Board of Directors at corresponding monthly board meetings. This will be done as situations arise.	4/7/2024

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S 685	Continued From page 24 Review of resident 2's care record revealed: *She was admitted on 9/29/23. *She had not been assessed to determine her ability to self-administer her insulin. *There was no physician's order for her to self-administer her insulin. Interview on 2/22/24 at 8:45 a.m. with director of nursing B regarding resident 2's self-administration of medication revealed she: *Was responsible to complete self-administration of medication assessments for residents and to obtain a physician's order when the resident was going to self-administer their own medications. *Confirmed there was no assessment or a physician order for resident 2 to self-administer her own medications. *Was uncertain as to why those had not been obtained.	S 685	3/28/2024 - The RN will use a self-administration of medication checklist as well as the resident's PCP in determining if a resident is able to self-administer medication. Any "at bedside" medications are counted bi-weekly by the UAP's and results reported to the RN. UAP's are encouraged to inform the RN or administrator if they notice anything out of character with a resident. The RN will conduct a new self-administration of medication at that time. All residents	

South Dakota Department of Health

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S 000	Compliance Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 4/22/24 for deficiencies cited on 2/22/24. All deficiencies have been corrected, and no new noncompliance was found. Golden Prairie Manor is in compliance with all regulations surveyed.	S 000		

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