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

PRINTED: 04/09/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		425000			С		
		435099	B. WING_	B. WING		04/03/2025	
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE 05 FJERESTAD AVENUE EAST		
ESTELLIN	E NURSING AND CARE	CENTER		E	STELLINE, SD 57234		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000			
	with 42 CFR Part 483 for Long Term Care for 4/1/25 through 4/3/25	th survey for compliance 3, Subpart B, requirements acilities was conducted from 5. Estelline Nursing And Care					
		rvey for compliance with 42 art B, requirements for Long					
	Term Care facilities w through 4/3/25. Areas resident neglect relate	vas conducted from 4/1/25 s surveyed included potential ed to a resident being left on led period of time. Estelline					
Ų.							
11121 - 124-11 - No. 120 11 - 1							
ARCIDATORY	DIDECTODE OF PROVINCE	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Jason Hanssen

Administrator

4/11/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435099	B. WNO	B. WING		04/03/2025	
NAME OF PROVIDER OR SUPPLIER  ESTELLINE NURSING AND CARE CENTER				20	TREET ADDRESS, CITY, STATE, ZIP CODE 05 FJERESTAD AVENUE EAST STELLINE, SD 57234		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
E 000	CFR Part 482, Subpa Emergency Prepared Term Care facilities w	ey for compliance with 42 art B, Subsection 483.73, ness, requirements for Long ras conducted on 4/3/25. Care Center was found in	E	€ 000	DEFICIENCY)		
ABORATORY	DIRECTOR'S OR PROVIDED	SUPPLIER REPRESENTATIVE'S SIGNAT	URE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Jason Hanssen

Administrator

4/11/2025

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		435099	B. WNG			04/03/2025	
NAME OF PROVIDER OR SUPPLIER  ESTELLINE NURSING AND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  205 FJERESTAD AVENUE EAST  ESTELLINE, SD 57234			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCY)				
K 000	INITIAL COMMENTS		K	000			
	for compliance with 4 requirements for Long	ey was conducted on 4/3/25 2 CFR 483.90 (a)&(b), g Term Care facilities. Care Center was found in					
		SLIDDI IED REDDESENTATIVE'S SIGNATI IDE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Jason Hanssen

Administrator

4/11/2025

PRINTED: 04/09/2025 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING 10617 04/03/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 FJERESTAD AVE E POST OFFICE BOX 130 **ESTELLINE NURSING AND CARE CENTER** ESTELLINE, SD 57234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 Compliance/Noncompliance Statement S 000 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted on from 4/1/25 through 4/3/25. Estelline Nursing And Care Center was found in compliance. S 000 Compliance/noncompliance Statement S 000 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/1/25 through 4/3/25. Estelline Nursing And Care Center was found in compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jason Hanssen

TITLE Administrator (X6) DATE

4/11/2025

KT1011