STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	436506	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE REHABILITATION	1720 S CLIFF AVE SIOUX FALLS, SD 57105

(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
I 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 485, Subpart H, Subsections 485.701-485.729, requirements for Outpatient Physical Therapy and Speech-language Pathology services, was conducted from 9/25/23 through 9/28/23 for Prairie Rehabilitation and the extension clinics in Brandon, Hartford, Harrisburg, Sioux Falls-West, Sioux Falls-East, Ponderosa Assisted Living Center, and Tea. Prairie Rehabilitation was found not in compliance with the following regulatory requirement: I161.	I 000		
I 161	INFECTION CONTROL COMMITTEE CFR(s): 485.725(a) The infection control committee establishes policies and procedures for investigating, controlling, and preventing infections in the organization and monitors staff performance to ensure that the policies and procedures are executed. This STANDARD is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *A facility-wide comprehensive infection control program was developed and implemented for the surveillance and prevention of infection control issues. *An infection control committee was established as part of the oversight of infection control issues, monitoring staff performance to ensure policies and procedures were implemented. *Staff were not co-mingling clean linen with	I 161	*Prairie Rehabilitation's entire infection control program is being reviewed and expanded by the Administrator and Compliance Officer to satisfy regulatory requirements. Policies and processes have been created and will be implemented as of 11/2/2023. These will be initially monitored 2 times per week at a minimum for a month by clinic leads with one of the weekly checks being completed by HR or another member of the infection control committee, whenever possible, using a thorough walk-through checklist. These checklists will be forwarded to the head of infection control by the end of the day of each check by email or fax. The head of infection control will review and follow up and provide education on any issues and will then keep on file. Any issues will be reported to Quality Assurance Committee. Clinic Leads for each location will receive in-person review and education on these policies and the new checklist on 11/7/2023 and will begin use as of 11/8/2023. Staff will be educated on new policies via policy review and attestation of understanding to be completed by 11/10/2023. Education completion will be monitored by head of infection control. *The infection control committee has been restructured and expanded to include more members of the staff as of 10/11/2023. A head of infection of control was determined on10/1/2023. The committee going forward will meet at least twice a year to ensure compliance with the infection control program. They will report to the Quality Assurance Committee.	11/12/2023

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

Lee Glasoe

TITLE
CEO/Administrator

(X6) DATE
11/1/2023

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

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I 161	Continued From page 1 therapy lotions, creams, and therapy assistive devices. *Clean linen was not stored on top of the dirty laundry baskets in the clinic. *Contact time for disinfection wipes were used in accordance with the manufacturer's direction for use. *Monthly walk through of each clinic area were documented and any action items had been completed. *The hydrocollator in two of two (Hartford Clinic and Sioux Falls West Clinic) extension services staff checked and documented temperatures consistent on the provider's log sheets. Findings include: 1. Observation and interview on 9/25/23 at 3:54 p.m. at the Prairie Rehabilitation Sioux Falls East Clinic revealed: *Physical therapist (PT) E disinfected the therapy table after a patient's treatment with an Everwipe disinfection wipe. -The surface of the therapy table only remained wet for approximately 30 seconds; and additional wipes were not used to reapply the disinfectant. -Review of the manufacturer's instructions for use with PT E confirmed the surface of the therapy table device should have remained visibly wet for five minutes. *The Purell hand sanitizer in the wall mounted dispenser had an expiration date of June 2021. *In the wall-mounted linen cabinet clean linen was stored on the same shelf with the following unclean items: -A jar of therapy cream, sanitizing wipes, a bottle of Isopropyl alcohol, a tube of Bonfire gel [cream for pain relief], a bottle of body lotion, and hand gel. -The above items were touching the clean linen.	I 161	a. East SF Findings a. Everwipes have been discontinued and staff are currently using Clorox Wipes according to package directions. We will be implementing new wipes with a lesser dry time to help ensure staff compliance. Staff has been re-educated on current wipe usage on 10/20/2023. Further education will be provided for policy of new wipes by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. New policy was implemented on 11/2/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. b. Expired products were removed from used and replaced with unexpired products by clinic supervisor on 9/26/202. Staff was educated on importance of checking expiration dates on 10/20/2023. Policies will be updated by 11/2/2023 to include watching for expiration dates and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. c. New storages options will be implemented to help keep therapy lotions/gels/assistive devices away from clean linen to prevent physical contact and potential contamination. Staff was educated on importance of proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee upon implementation via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. d. Staff was educated about cleanliness expectations on 9/26/2023 and office was deeply cleaned by PCC on 9/26/2023. Policies for housekeeping and cleaning will be updated by 11/2/2023 to detail expectations and education on new polices will be provided by either head of infection control or another member of the infection control committee upon implementation via policy review and attestation of understanding to be completed by 11/10/2023. . Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance.	

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I 161	Continued From page 2 *The exercise equipment and windowsills has a layer of dust on them. -Interview at the time of the above observations with patient care technician (PCT) C confirmed those observations. --She had noticed that and brought a Sweeper duster for that purpose. --She completed her cleaning when there was no one in the clinic. Continued observation and interview on 9/25/23 at 4:45 p.m. of two patient treatment areas with PCT C revealed: *Each room had a laundry basket that was partially full of dirty laundry. *Each laundry basket had three pillows lying on top of them. *PCT C confirmed: -All of the pillows were clean and had been ready for patient use while receiving treatment on the therapy beds. -The pillows would have remained on top of the soiled linen laundry baskets after they were cleaned. -Agreed there was a potential for contamination to the pillows when the staff opened the laundry basket and placed soiled linens inside. 2. Observation on 9/26/23 at 8:37 a.m. at the Prairie Rehabilitation Sioux Falls West clinic revealed: *One hydrocollator in the curtained off treatment area. -Interview with PT F at the time of the observation confirmed the temperature of the hydrocollator was checked daily but was not documented. -Interview on 9/26/23 at 9:06 a.m. with PT F confirmed the temperature was taken daily but was not documented to reference later if needed.	I 161	1. East SF Findings continued a. Pillows have been relocated away from items that could cause cross-contamination and new storage options are being researched and trialled to implement permanent storage options to be able to store pillows away from soiled laundry. Staff was educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. 2. West SF Findings a. Hydrocullator has been discontinued from use. Checklists and policies for other clinics with a Hydrocullator will be updated and implemented by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. b. New storages options will be implemented to help keep therapy lotions/gels/assistive devices away from clean linen to prevent physical contact and potential contamination. Staff was educated on proper storage on 10/20/2023. Policies will be updated by 11/2/2023 to detail proper storage and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023.. Walk-through checklists will be implemented by 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will c. Wooden assistive devices that are bare or a non-cleanable surface will be painted to create a cleanable surface and will be kept out of use until painting is completed or additional hand washing and sanitizing will happen before and after handling. Staff was educated on proper handling of these items and reporting issues on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance.	

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I 161	Continued From page 3 *Therapy room 1 had the following items: -A wall mounted linen storage cabinet on the first shelf had the following items touching clean linen: --A box of Kleenex; Pene --Stored bottles of Lubriderm and Curel lotion. --Wooden assistive devices with the paint missing in large areas making the device noncleanable. -Several blue squared therapy stand devices had deep grooves and cracks with uncleanable surfaces bilateral. 3. Observation and interview on 9/26/23 at 9:47 a.m. at the Prairie Rehabilitation Hartford clinic with PT manager J and patient care coordinator (PCC) K revealed: *One of two blue squared therapy stand devices had deep grooves and cracks. Those grooves and cracks had created an uncleanable surface. -They were aware of those cracked and open surfaces of the therapy standing device. -They were not aware that those open and grooved areas had created an unclean surface. *One hydrocollator located inside a curtained off treatment room. -The hydrocollator was used almost daily. -The temperature of the water was not consistently checked by staff. -It was cleaned monthly and the water level was checked every week. -The water temperature checks, level checks, and cleaning of the hydrocollator was not documented to ensure the safety of the patients from burns and infections had occurred. -PCC K stated: "We just trust that it's done and okay to use." "We rely on word of mouth." 4. Observation on 9/26/23 at 11:10 a.m. at the Prairie Rehabilitation Tea clinic revealed: *Three treatment rooms with wall-mounted linen	I 161	2. West SF Findings continued. d. Blue therapy stand devices will be replaced with new and staff will complete hand washing before and after handling current pads until they are replaced. Staff was educated n proper handling and reporting of issues on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. 3. Hartford Findings a. Blue therapy stand devices have been discarded and removed from use. Staff was educated n proper handling and reporting of issues on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. b. Hydrocullator has been discontinued from use. Checklists and policies for other clinics with a Hydrocullator will be updated and implemented by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance.	

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I 161	Continued From page 4 cabinets with unclean therapy items that had come in contact with clean linen. Those items included the following: -Lubriderm lotion. -A roll of paper towel on top of the clean linen. -A tub of therapy massage cream. -A tub of coco moisturizing butter. -A tape measurer and various therapy equipment that would have been used during the patient treatments. -A bottle of Isopropyl alcohol. *The laundry room had patient drinking cups on linen soiled with laundry detergent, an open box of community use spoons encased in a plastic bag that was open. -Those same cups were observed on top of the water cooler. *There was a collection tray attached to the water cooler that was dirty with a gray type substance. Interview on 9/26/23 at 11:40 a.m. with patient care coordinator (PCC) L regarding the above observations revealed: *She confirmed that was their usual practice for storing various therapy supplies with the clean linens. *The staff had not realized those processes could have created a potential for cross-contamination of bacteria to occur from one patient to another. *She was not aware of a cleaning process for the collection tray attached to the water machine. *She stated: "I never use it, so I didn't even know it was dirty." 5. Observation on 9/26/23 at 1:40 p.m. at the Prairie Rehabilitation Harrisburg clinic revealed: *Clean pillows were stored on top of the soiled laundry baskets. *A wall-mounted linen cabinet for storage of linen	I 161	4. Tea Findings a. New storages options will be implemented to help keep therapy lotions/gels/assistive devices away from clean linen to prevent physical contact and potential contamination. Staff was educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023.. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. b. Issues with patient cup and spoon storage were resolved on 9/27/2023 after staff education. These items were moved to a separate storage cabinet that has not items that could contaminate their use. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. c. Water cool tray was cleaned on 9/27/2023 after staff education on cleanliness expectations and policies will be implemented to better detail expectations for housekeeping by 11/2/2023 and clinic cleaning and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. 5. Harrisburg Findings a. Pillows have been relocated away from items that could cause cross-contamination and new storage options are being researched and trialled to implement permanent storage options to be able to store pillows away from soiled laundry. Staff was educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023.. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance.	

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I 161	Continued From page 5 comingled with therapy creams, lotions, Biofreeze, Kleenex, Clorox disinfection wipes, pens, tape measure, baseline evaluation instruments, and a plastic ball on top of the pillowcases. *Six-inch foam roller with the ends discolored grayish to light black stored upright in the corner. *A five-inch red rod with discolored tan taped used to ensure grip. *Two therapy beds with a dime size tear in the plastic protective covering that exposed the wood underneath making it uncleanable in that area. Interview on 9/26/23 at 2:08 p.m. with PCT G confirmed: *The condition of the above-listed items. *The plastic ball should not have been stored with the clean linen. *The other supplies should not have been stored with the clean linens. *She was responsible for the cleaning and upkeep of the clinic. *She agreed the pillows had the potential for cross-contamination of bacteria when any soiled linens were placed in the laundry baskets. 6. Observation on 9/26/23 from 3:20 p.m. through 3:40 p.m. at the Prairie Rehabilitation Clinic Brandon revealed: *The same infection control concerns as identified above: -Clean pillows stored on top of soiled laundry baskets. -Multiple creams, cleaners, lotions, Isopropyl alcohol, and various therapy equipment for measuring areas on the patients had been stored with the clean linens. Those items were directly touching the clean linens. -Various-sized wooden boards used with the	I 161	5. Harrisburg Findings Continued b. New storages options will be implemented to help keep therapy lotions/gels/assistive devices away from clean linen to prevent physical contact and potential contamination. Staff was educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023.. Walk-through checklists will be implemented on 11/8/2023and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will c. Foam roller will be replaced with new and staff will complete hand washing before and after handling current roll until it is replaced as well as using a towel as a barrier between roll and patient during patient use. Covers will also be ordered for foam rolls throughout the company and we are also researching options with more cleanable surfaces. Staff was educated on proper handling and reporting on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. d. Red rod at this facility will be replaced with an item that has a cleanable surface. Until replacement, staff will wash their hands before and after handling. Staff was educated on proper handling and reporting on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control If continuation or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. e. We will be replacing the upholstery of these two therapy tables. Until that is replaced, cleanable patches will be placed on the tables or the tables will be discontinued from service until they are repaired. Staff was educated on proper reporting of issues on 10/20/2023. Policies will be created to implement a better reporting and replacement by 11/2/2023 and education on new policies will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk -through checklists will be implemented on 11/8/2023 and utilized observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance.	

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I 161	Continued From page 6 patients during their treatment sessions. Those boards had areas of exposed wood that created an unclean surface. -Two blue squared standing devices that had cracked and grooved areas. Those areas created unclean surfaces. Interview on 9/27/23 at 2:02 p.m. with corporate compliance officer M revealed: *She was not aware of all the infection control and safety concerns identified above at the therapy clinics. *She agreed: -Those processes had created the potential for cross contamination of bacteria to have been transferred from one patient to another. -The two clinics with hydrocullator's had not been managing and monitoring them according to their policy to ensure the safety of the patients and to prevent injury. *She was not the infection control coordinator and to her knowledge there was no program in place. *The staff would have received yearly mandatory training on blood-borne pathogens. *There was no infection control surveillance to support the following: -All the staff understood and used the disinfectant cleaning products accurately to ensure wet times were followed per manufacturer instructions. -There was no co-mingling of therapy products and equipment with the clean linens. -The proper storage of clean pillows occurred in between patient treatment sessions. -All the equipment was in good repair to ensure all surfaces were intact and cleanable. -The staff had documentation in place to support the hydrocollator had been cleaned according to their policy. -The laundry rooms and storage areas were	I 161	6. Brandon Findings a. Pillows have been relocated away from items that could cause cross-contamination and new storage options are being researched and trialled to implement permanent storage options to be able to store pillows away from soiled laundry. Staff has been educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. b. b. New storages options will be implemented to help keep therapy lotions/gels/assistive devices away from clean linen to prevent physical contact and potential contamination. Staff has been educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. . Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance at a minimum of 2 times per week for at least one month and will reassessed at that time based on compliance. c. c. Wooden assistive devices that are bare or a non-cleanable surface will be painted to create a cleanable surface and will be kept out of use until that is completed or additional hand washing and sanitizing will happen before and after handling. Staff has been educated on proper handling and reporting on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented on 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance. d. d. Blue therapy stand devices will be replaced with new and staff will complete hand washing before and after handling current pads until they are replaced. Staff has been educated on proper handling and reporting on 10/20/2023. Policies will be created to implement a better reporting and replacement process by 11/2/2023 and education on new polices will be provided by either head of infection control or another member of the infection control committee via policy review and attestation of understanding to be completed by 11/10/2023. Walk-through checklists will be implemented by 11/8/2023 and utilized to observe and monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and will be reassessed at that time based on compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	436506	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE REHABILITATION	1720 S CLIFF AVE SIOUX FALLS, SD 57105

(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
I 161	Continued From page 7 maintained in a clean manner. *There was no program in place to review for infection control practices to ensure the safety and well-being of the patients that who received treatment and services had occurred. *To her knowledge the administrator completed monthly walk-thru of all the clinics. -She was not sure what was checked or done during those walk-thrus. -Those walk-thrus were not reviewed in the quality assurance compliance meetings. -She was not aware of any meeting minutes or documentation from those walk-thrus. *There were no audits conducted to be reviewed with the staff. *She stated: -"I work from home so I would not be able to do any audits on the staff." -"I was not aware that infection control was part of the compliance program." Interview on 9/28/23 at 10:55 a.m. with administrator A revealed: *He confirmed there was no infection control or surveillance program in place. *He was aware of the therapy equipment and creams that had been stored with the clean linens. *He stated: -"We have been doing that for years and now it's just an issue?" -"No, they should not be storing the pillows on the soiled linen baskets." -"We don't do any training on the use of disinfectant wipes or the Clorox wipes. They should be aware of how to use them." -"No, there is no specific infection control training set-up for cleaning the clinics." *He had not realized:	I 161		

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I 161	Continued From page 8 -The unpainted surfaces of wood were not cleanable. -The cracks and grooves found on the blue square standing devices had created an unclean surface. *He stated: -"Both of those are used for standing on. How is that any different from the carpet -"We don't clean the carpet everyday?" -"True, the therapists would have to handle and move them around for the patients to use." -"I just never considered that to be unclean." -"Yes, we do monthly rounds in the clinics. We might talk about cleanliness concerns." -"But we have never made it as such a high priority as this." -"We talk about infection control twice a year, but that is mostly just healthcare things." -"Didn't realize they weren't monitoring the temp [temperature] and documenting it and the cleanings on the hydrocullators. They should be." Review of the provider's undated Cleaning Equipment policy revealed: *"The following guidelines are recommended as standard procedure to minimize the spread of infectious disease or illness. These procedures shall be used for all equipment." *"Cleaner to be used includes the following: disposable cleaning wipes or spray with germicidal solution. -Use disposable cleaning wipe or germicidal spray solution. -Allow treatment table to adequately dry between patient treatments." Review of the provider's undated Storage and Handling of Laundry policy revealed: *"Do not place any clean laundry in the baskets	I 161		

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I 161	Continued From page 9 that hold dirty laundry." *"You must keep a separate basket available for only the clean laundry." Review of the provider's undated Infection Control Committee policy revealed: *"The Corporate Compliance Officer will schedule infection control meetings biannually with the Quality Assurance meetings. Members of the infection control committee will consist of the CEO/Administrator, SD Outreach Manager, MN [Minnesota] Outreach Manager, Corporate Compliance Officer, Human Resources Manager, and may include other employees or supervisors at the discretion of the Administrator." *"Duties include the following: -Oversee infection control policies. -Oversee staff education." Review of the provider's undated Cleaning Hydrocollator policy revealed: *"Daily: -Check the temperature of the Hydrocollator once daily. Temperature should fall between 158 degrees [Fahrenheit] and 167 degrees [Fahrenheit]." -There was no process in place to support how the staff would have ensured the hydrocollator temperature was checked daily. *The Hydrocollator was to have been rinsed out weekly and followed by a quarterly cleaning. -There was documentation on how to complete those required processes. -There was no no process in place to support how the staff would have ensured the hydrocollator had been cleaned per their policy.	I 161		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 485, Subpart H, Subsection 485.727, Emergency Preparedness, requirements for Outpatient Physical Therapy and Speech-language Pathology Services was conducted from 9/25/23 through 9/28/23. Prairie Rehabilitation was found in compliance.	E 000		

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

Lee Glasoe | CEO/Administrator | 10/20/202

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

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	436506	A. BUILDING _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE REHABILITATION	1720 S CLIFF AVE SIOUX FALLS, SD 57105

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I 000	INITIAL COMMENTS A revisit survey was conducted for compliance with 42 CFR Part 485, Subpart H, Subsections 485.701-485.729, requirements for Outpatient Physical Therapy and Speech-Language Pathology services, was conducted on 11/14/23 for deficiencies cited on 9/28/23. All deficiencies have been corrected, and no new noncompliance was found. Prairie Rehabilitation was found in compliance.	I 000		

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