PRINTED: 10/11/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		E SURVEY IPLETED
ļ		436506	B. WING		09	9/28/2023
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 720 S CLIFF AVE IOUX FALLS, SD 57105	1 0.	12020
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1 000	INITIAL COMMENTS	5	1 000			
l 161	with 42 CFR Part 48: 485.701-485.729, rei Physical Therapy and Pathology services, in through 9/28/23 for File extension clinics in B Sioux Falls-West, Sid Assisted Living Cente Rehabilitation was for the following regulate INFECTION CONTR CFR(s): 485.725(a) The infection control policies and procedu controlling, and preve organization and more ensure that the policie executed. This STANDARD is Based on observation and policy review, the the following: *A facility-wide comp program was develop surveillance and previous issues. *An infection control as part of the oversig monitoring staff perforand procedures were	was conducted from 9/25/23 Prairie Rehabilitation and the trandon, Hartford, Harrisburg, bux Falls-East, Ponderosa er, and Tea. Prairie und not in compliance with bry requirement: I161. OL COMMITTEE committee establishes res for investigating, enting infections in the nitors staff performance to es and procedures are not met as evidenced by: on, interview, record review, e provider failed to ensure rehensive infection control oed and implemented for the vention of infection control committee was established that of infection control issues, ormance to ensure policies	I 161	*Prairie Rehabilitation's entire infection control program is being reviewed a expanded by the Administrator and Compliance Officer to satisfy regular requirements. Policies and process been created and will be implement 11/2/2023. These will be initially most times per week at a minimum for a clinic leads with one of the weekly obeing completed by HR or another of the infection control committee, we possible, using a thorough walk-through checklist. These checklists will be for to the head of infection control by the day of each check by email or false head of infection control will review follow up and provide education on issues and will then keep on file. Ar will be reported to Quality Assurance Committee. Clinic Leads for each lowill receive in-person review and econ these policies and the new check 11/7/2023 and will begin use as of 11/8/2023. Staff will be educated or policies via policy review and attest understanding to be completed by 11/10/2023. Education completion will ment at least false of 10/11/20 head of infection control committee has restructured and expanded to inclumembers of the staff as of 10/11/20 head of infection of control was det on 10/1/2023. The committee going will meet at least twice a year to encompliance with the infection control program. They will report to the Quality Assurance Committee.	and attory es have eed as of enitored 2 month by checks member whenever bugh brwarded he end of ax. The and any hy issues e cation lucation klist on h new ation of will be rol. as been de more bugs. A ermined forward sure bul	11/12/2023
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE CEO/Administrat	or	(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 (Sepinstructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not applaced correction is provided. For hursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deticiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Ver

Event ID: 89 F

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1888 (0	G	COMPLETED
		436506	B. WING _		09/28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 S CLIFF AVE SIOUX FALLS, SD 57105	
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I 161	therapy lotions, creat devices. *Clean linen was no laundry baskets in the Contact time for distaccordance with the use. *Monthly walk through documented and an completed. *The hydrocollator in and Sioux Falls West staff checked and doconsistent on the profindings include: 1. Observation and p.m. at the Prairie Rollinic revealed: *Physical therapist of table after a patient disinfection wipe. -The surface of the wet for approximate wipes were not useReview of the man with PT E confirmed table device should five minutes. *The Purell hand sad dispenser had an extended on the same unclean items: -A jar of therapy creof Isopropyl alcohol for pain relief], a bogel.	t stored on top of the dirty ne clinic. sinfection wipes were used in manufacturer's direction for the dirty direction wipes were used in manufacturer's direction for the direction for the direction items had been the two of two (Hartford Clinic at Clinic) extension services ocumented temperatures	11	a. East SF Findings a. Everwipes have been discontinued and sta using Clorox Wipes according to package will be implementing new wipes with a less help ensure staff compliance. Staff has be on current wipe usage on 10/20/2023. Further education will be provnew wipes by either head of infection continuments of the infection control committee review and attestation of understanding to by 11/10/2023. New policy was implement 11/2/2023. Walk-through checklists will be 11/8/2023 and utilized to observe and mor at a minimum of 2 times per week for at leand will be reassessed at that time based b. Expired products were removed from used with unexpired products by clinic supervist Staff was educated on importance of checklates on 10/20/2023. Policies will be updated by 11 include watching for expiration dates and new polices will be provided by either head control or another member of the infection committee via policy review and attestation understanding to be completed by 11/10/2 through checklists will be implemented on utilized to observe and monitor complianc of 2 times per week for at least one month reassessed at that time based on complia c. New storages options will be implemented therapy lotions/gels/assistive devices awa linen to prevent physical contact and pote contamination. Staff was educated on imp proper storage on 10/20/2023. Policies will detail proper storage by 11/2/2023 and ed polices will be provided by either head of it or another member of the infection control implementation via policy review and attest understanding to be completed by 11/10/2 through checklists will be implemented on utilized to observe and monitor complianc of 2 times per week for at least one month reassessed at that time based on complia d. Staff was educated about cleanliness exp 9/26/2023. Policies for housekeeping and updated by 11/2/2023 to detail expectation on new polices will be provided by either hountry of another member of the infection committee upon implementation via policy attestation of understanding to be c	directions. We er dry time to en re-educated ded for policy of ol or another via policy be completed ed on implemented on itor compliance ast one month on compliance, and replaced or on 9/26/202. king expiration (2/2023 to education on do finection control of of infection control of the detailed of th

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 S CLIFF AVE SIOUX FALLS, SD 57105		
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J 161	layer of dust on then -Interview at the time with patient care tec those observationsShe had noticed th duster for that purpoShe completed her one in the clinic. Continued observati at 4:45 p.m. of two p PCT C revealed: *Each room had a la partially full of dirty la *Each laundry basks top of them. *PCT C confirmed: -All of the pillows we for patient use while therapy bedsThe pillows would h soiled linen laundry cleanedAgreed there was a to the pillows when t basket and placed s 2. Observation on 9/ Prairie Rehabilitation revealed: *One hydrocollator in areaInterview with PT F confirmed the tempe was checked daily b -Interview on 9/26/2: confirmed the tempe	ment and windowsills has a n. e of the above observations hincian (PCT) C confirmed at and brought a Sweeper se. I cleaning when there was no on and interview on 9/25/23 eatient treatment areas with sundry basket that was aundry. Et had three pillows lying on the clean and had been ready receiving treatment on the baskets after they were potential for contamination the staff opened the laundry	I 161	1. East SF Findings continued a. Pillows have been relocated away from items cause cross-contamination and new storage optibeing researched and trialled to implement perm storage options to be able to store pillows away laundry. Staff was educated on proper storage o 10/20/2023. Policies will be updated to detail proby 11/2/2023 and education on new polices will by either head of infection control or another merinfection control committee via policy review and of understanding to be completed by 11/10/2023 through checklists will be implemented on 11/8/2 utilized to observe and monitor compliance at a 12 times per week for at least one month and will reassessed at that time based on compliance. 2. West SF Findings a. Hydrocullator has been discontinued from use and policies for other clinics with a Hydrocullat updated and implemented by 11/2/2023 and enew polices will be provided by either head of control or another member of the infection concommittee via policy review and attestation of understanding to be completed by 11/10/2023 through checklists will be implemented 11/8/2 utilized to observe and monitor compliance at of 2 times per week for at least one month and reassessed at that time based on compliance at of 2 times per week for at least one month ana reassessed at that time based on compliance at of 2 times per week for at least one month and reassessed at that time based on compliance at of 2 times per week for at least one month and reassessed at that time based on compliance at of 2 times per week for at least one month and reassessed at that time based on compliance at of 2 times per week for at least one month and reassessed at that time based on compliance at one month and will contamination. Staff was educated on proper 10/20/2023. Policies will be updated by 11/2/2 proper storage and education on new polices provided by either head of infection control committee via review and attestation of understanding to be by 11/10/2023. Walk-through checklists will be implemented by 11/8/2023 and utili	ons are anent from soiled in per storage per provided in per storage on the storage of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	
		436506	B. WING		09/2	28/2023
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP COD 720 S CLIFF AVE SIOUX FALLS, SD 57105		
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I 161	*Therapy room 1 h -A wall mounted lin shelf had the followA box of KleenexStored bottles ofWooden assistive in large areas mak -Several blue squadeep grooves and surfaces bilateral. 3. Observation and a.m. at the Prairie with PT manager J (PCC) K revealed: *One of two blue s had deep grooves and cracks had cre -They were aware surfaces of the the -They were not aw grooved areas had *One hydrocollator treatment roomThe hydrocollator treatment roomThe temperature consistently check -It was cleaned mon checked every well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining-PCC K stated: "Wookay to use." "Well-the water temper and cleaning of the documented to enfrom burns and infining temper and cleaning of the documented to enfrom burns and inf	and the following items: iven storage cabinet on the first iving items touching clean linen: ; Pene Lubriderm and Curel lotion. dedevices with the paint missing ing the device noncleanable. Ired therapy stand devices had cracks with uncleanable definiterview on 9/26/23 at 9:47 Rehabilitation Hartford clinic and patient care coordinator quared therapy stand devices and cracks. Those grooves and cracks. Those grooves and cracks and open arapy standing device. Therefore that those open and definite that the thintent	I 161	2. West SF Findings continued. d. Blue therapy stand devices we with new and staff will complete before and after handling currer are replaced. Staff was educate handling and reporting of issues Policies will be created to imple reporting and replacement proceand education on new polices weither head of infection control policy review and attestation of be completed by 11/10/2023. We checklists will be implemented utilized to observe and monitor initiate repair/replacement proceof 2 times per week for at least will be reassessed at that time is compliance. 3. Hartford Findings a. Blue therapy stand devices has and removed from use. Staff we proper handling and reporting 10/20/2023. Policies will be created by 11/10/202 checklists will be implemented utilized to observe and monitor initiate repair/replacement proceof 2 times per week for at least be completed by 11/10/202 checklists will be implemented utilized to observe and monitor initiate repair/replacement proceof 2 times per week for at least be reassessed at that time base hydrocullator has been discorned the completed by 11/10/202 checklists and policies for oth Hydrocullator will be updated 11/2/2023 and education on provided by either head of infeanother member of the infectivity policy review and attestative be completed by 11/10/202 checklists will be implemented utilized to observe and monitor in provided by either head of infeanother member of the infectivity policy review and attestative be completed by 11/10/202 checklists will be implemented utilized to observe and monitor in provided by either head of infeanother member of the infectivity policy review and attestative be completed by 11/10/202 checklists will be implemented utilized to observe and monitor minimum of 2 times per week month and will be reassessed on compliance.	will be replaced hand washing in pads until they ed in proper is on 10/20/2023. Imment a better ress by 11/2/2023 will be provided by or another committee via understanding to Walk-through on 11/8/2023 and compliance and ess at a minimum one month and based on a seed of the provided was educated in of issues on the process by the polices will be ection control committee on of understanding its. Walk-through in on 11/8/2023 and or compliance and ress at a minimum ist one month and will issed on compliance. In the property of the property is the property of the property is the provided with a land implemented by the property is the property of the	

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I 161	come in contact with included the following -Lubriderm lotionA roll of paper towel -A tub of therapy mas -A tub of coco moistural -A tub of coco moistural -A tape measurer and that would have been treatmentsA bottle of Isopropyl *The laundry room has linen soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of community use spicial based on the soiled with laun of collections reveale *She confirmed that is storing various theraption of bacteria to occur for the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a potential based on the staff had not reach a st	on top of the clean linen. sage cream. urizing butter. d various therapy equipment n used during the patient alcohol. ad patient drinking cups on dry detergent, an open box oons encased in a plastic ere observed on top of the on tray attached to the water with a gray type substance. at 11:40 a.m. with patient C) L regarding the above d: was their usual practice for py supplies with the clean alized those processes could atial for cross-contamination from one patient to another. of a cleaning process for the ed to the water machine. use it, so I didn't even know 26/23 at 1:40 p.m. at the Harrisburg clinic revealed: stored on top of the soiled	116	keep therapy lotions/gels/assistive device from clean linen to prevent physical contapotential contamination. Staff was educate proper storage on 10/20/2023. Policies will updated to detail proper storage by 11/2/2 education on new polices will be provided head of infection control or another membrinfection control committee via policy reviattestation of understanding to be comple 11/10/2023. Walk-through checklists will implemented on 11/8/2023 and utilized to and monitor compliance at a minimum of week for at least one month and will be reat that time based on compliance. b. Issues with patient cup and spoon storage resolved on 9/27/2023 after staff education items were moved to a separate storage of has not items that could contaminate their Walk-through checklists will be implement 11/8/2023 and utilized to observe and mocompliance and initiate repair/replacement at a minimum of 2 times per week for at lemonth and will be reassessed at that time compliance. c. Water cool tray was cleaned on 9/27/2023 education on cleanliness expectations an will be implemented to better detail expect housekeeping by 11/2/2023 and clinic cleed education on new polices will be provided head of infection control or another membring infection control committee via policy reviattestation of understanding to be comple 11/10/2023. Walk-through checklists will be implemented on 11/023 and utilized to obtain monitor compliance and initiate repair/repprocess at a minimum of 2 times per weel least one month and will be reassessed a based on compliance. 5. Harrisburg Findings a. Pillows have been relocated away from items the cause cross-contamination and new storage options to be able to store pillows away soiled laundry. Staff was educated on proper storage options to be able to store pillows away soiled laundry. Staff was educated on proper storage by 11/2/2023. Policies will be updated to detail p storage by 11/2/2023 and education on new pol provided by either head of infection control committee via review and attestation of u	is away ict and ed on ill be 2023 and by either per of the iew and ied by be observe 2 times per cassessed e were on. These cabinet that r use. ted on nitor int process cast one based on 3 after staff d policies tations for aning and by either per of the iew and ted by be osserve and lacement k for at t that time at could official staff or one or oper ices will be inother policy ompleted rve and er week for
	laundry baskets.	n cabinet for storage of linen			er week for

Facility ID: 436506

PRINTED: 10/11/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 436506 09/28/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1720 S CLIFF AVE PRAIRIE REHABILITATION SIOUX FALLS, SD 57105 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 5. Harrisburg Findings Continued b. New storages options will be implemented to help keep 1161 therapy lotions/gels/assistive devices away from clean linen Continued From page 5 1161 to prevent physical contact and potential contamination. Staff comingled with therapy creams, lotions, was educated on proper storage on 10/20/2023. Policies will be updated to detail proper storage by 11/2/2023 and Biofreeze, Kleenex, Clorox disinfection wipes. education on new polices will be provided by either head of pens, tape measure, baseline evaluation infection control or another member of the infection control committee via policy review and attestation of understanding instruments, and a plastic ball on top of the to be completed by 11/10/2023.. Walk-through checklists will pillowcases. be implemented on 11/8/2023and utilized to observe and monitor compliance at a minimum of 2 times per week for at *Six-inch foam roller with the ends discolored least one month and will grayish to light black stored upright in the corner. c. Foam roller will be replaced with new and staff will *A five-inch red rod with discolored tan taped complete hand washing before and after handling current roll until it is replaced as well as using a towel as a barrier used to ensure grip. between roll and patient during patient use. Covers will also *Two therapy beds with a dime size tear in the be ordered for foam rolls throughout the company and we are also researching options with more cleanable surfaces. Staff plastic protective covering that exposed the wood was educated on proper handling and reporting on underneath making it uncleanable in that area. 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 Interview on 9/26/23 at 2:08 p.m. with PCT G infection control or another member of the infection control committee via policy review and attestation of understanding confirmed: to be completed by 11/10/2023. Walk-through checklists will *The condition of the above-listed items. be implemented on 11/8/2023 and utilized to observe and *The plastic ball should not have been stored with monitor compliance and initiate repair/replacement process at a minimum of 2 times per week for at least one month and the clean linen. will be reassessed at that time based on compliance. *The other supplies should not have been stored d. Red rod at this facility will be replaced with an item that has a cleanable surface. Until replacement, staff will wash their with the clean linens. hands before and after handling. Staff was educated on *She was responsible for the cleaning and proper handling and reporting on 10/20/2023. Policies will be created to implement a better reporting and replacement upkeep of the clinic. process by 11/2/2023 and education on new polices will be *She agreed the pillows had the potential for provided by either head of infection control If continuation or another member of the infection control committee via policy cross-contamination of bacteria when any soiled review and attestation of understanding to be completed by linens were placed in the laundry baskets. 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 6. Observation on 9/26/23 from 3:20 p.m. through times per week for at least one month and will be reassessed 3:40 p.m. at the Prairie Rehabilitation Clinic at that time based on compliance. e. We will be replacing the upholstery of these two therapy

touching the clean linens.

Brandon revealed:

identified above:

baskets.

*The same infection control concerns as

-Clean pillows stored on top of soiled laundry

-Multiple creams, cleaners, lotions, Isopropyl

measuring areas on the patients had been stored

with the clean linens. Those items were directly

-Various-sized wooden boards used with the

alcohol, and various therapy equipment for

tables. Until that is replaced, cleanable patches will be placed on the tables or the tables will be discontinued from service

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

be reassessed at that time based on compliance.

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

until they are repaired. Staff was educated on proper

reporting of issues on

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	REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 S CLIFF AVE SIOUX FALLS, SD 57105		
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I 161	patients during their to boards had areas of an unclean surface. -Two blue squared st cracked and grooved unclean surfaces. Interview on 9/27/23 compliance officer M *She was not aware of and safety concerns in the the therapy clinics. *She agreed: -Those processes had cross contamination of transferred from one transf	reatment sessions. Those exposed wood that created anding devices that had areas. Those areas created at 2:02 p.m. with corporate revealed: of all the infection control dentified above at the discretized to have been patient to another. Involved the patients and to control coordinator and re was no program in place. It received yearly mandatory the pathogens. On control surveillance to coordinate to another was no program in place. It received yearly mandatory the pathogens. On control surveillance to coordinate to another west times and to control surveillance to coordinate to ensure wet times and and used the disinfectant curately to ensure wet times and acturer instructions. The clean linens. Of clean pillows occurred in ment sessions. It is in good repair to ensure	116	6. Brandon Findings a. Pillows have been relocated away from cause cross-contamination and new stora being researched and trialled to impleme storage options to be able to store pillows laundry. Staff has been educated on prop 10/20/2023. Policies will be updated to dby 11/2/2023 and education on new polic by either head of infection control or anot infection control committee via policy rev of understanding to be completed by 11/1 through checklists will be implemented 11 utilized to observe and monitor complianc 2 times per week for at least one month a reassessed at that time based on complia bb. New storages options will be implement therapy lotions/gels/assistive devices away to prevent physical contact and potential has been educated on proper storage on Policies will be updated to detail proper si and education on new polices will be provided infection control or another member of committee via policy review and attestati to be completed by 11/10/2023. Walk-thwill be implemented on 11/8/2023 and util and monitor compliance at a minimum of for at least one month and will reassesse based on compliance. c. c. Wooden assistive devices that are bare cleanable surface will be painted to create surface and will be kept out of use until the additional hand washing and sanitizing will and after handling. Staff has been educated handling and reporting on 10/20/2023. Pocreated to implement a better reporting and process by 11/2/2023 and education on no provided by either head of infection control committee and attestation of understanding to be contil/10/2023. Walk-through checklists will be 11/8/2023 and utilized to observe and mo and initiate repair/replacement process at times per week for at least one month and reassessed at that time based on compliand diffection control or another member of the committee via policy review and attestation be completed by 11/10/2023. Walk-through checklists will be reporting and replacement process by 11/education on new polices will be created to impreporting and replacement	age options are not permanent a wary from soiled are storage on etail proper storage as will be provided her member of the iew and attestation 0/2023. Walk-//8/2023 and we at a minimum of not will be innece. It was a minimum of not will be innece as a clean and the infection control on of understanding rough checklists ized to observe 2 times per week d at that time are considered as a clean able at is completed or II happen before ed on proper licies will be and replacement ew polices will be and replacement ew polices will be not on the proper licies will be not entered with the proper licies will be not entered with the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the proper licies will be not entered with the word of the word o	

PRINTED: 10/11/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 436506 B WING 09/28/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1720 S CLIFF AVE PRAIRIE REHABILITATION SIOUX FALLS, SD 57105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1161 Continued From page 7 1 161 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:

just an issue?"

soiled linen baskets."

*He had not realized:

-"We have been doing that for years and now it's

-"No, they should not be storing the pillows on the

-"No, there is no specific infection control training

-"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."

set-up for cleaning the clinics."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 S CLIFF AVE SIOUX FALLS, SD 57105		12.1	
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I 161	cleanableThe cracks and groc square standing devi surface. *He stated: -"Both of those are us that any different from the carpet everyday? -"True, the therapists move them around for "I just never conside -"Yes, we do monthly might talk about clean -"But we have never priority as this." -"We talk about infect that is mostly just hear -"Didn't realize they we [temperature] and do cleanings on the hydromapholicy revision with the construction of the provide Equipment policy revision of the provide standard procedure to infectious disease or shall be used for all eximple and spray solutionUse disposable cleaning was germicidal solutionUse disposable cleaning was germicidal solutionAllow treatment table patient treatments."	eves found on the blue des had created an unclean sed for standing on. How is in the carpet -"We don't clean " would have to handle and or the patients to use." red that to be unclean." rounds in the clinics. We inliness concerns." made it as such a high tion control twice a year, but althcare things." weren't monitoring the temp cumenting it and the rocullators. They should be." er's undated Cleaning ealed: lines are recommended as or minimize the spread of illness. These procedures quipment." includes the following:		161			
	Handling of Laundry	_					

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 436506 R WING 09/28/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1720 S CLIFF AVE PRAIRIE REHABILITATION SIOUX FALLS, SD 57105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1161 1 161 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.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	
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NAME OF PROVIDER OR SUPPLIER PRAIRIE REHABILITATION		172	EET ADDRESS, CITY, STATE, ZIP CODE 0 S CLIFF AVE DUX FALLS, SD 57105	1 00/2	.072020	
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E 000	A recertification surve CFR Part 485, Subpa Emergency Prepared Outpatient Physical T Speech-language Par	thology Services was 23 through 9/28/23. Prairie	E 000	DEFICIENCY)		
ABORATORY D	IRECTOR'S OR PROVIDER <i>IS</i> I	JPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	200	DATE
l ee Gl				CEO/A drainiate		DATE

CEO/Administrator

10/20/202

Any deficiency statement ending with an asierist?") denotes a deficiency other safeguards provide sufficient protection to the pettents. (See instructional following the date of survey whether or not a plan of correction is provided days following the date these documents are made available to the facility program participation. he institution may be excused from correcting providing it is determined that cons. Except for nursing homes, the findings stated above are disclosable 90 days
For nursing homes, the above findings and plans of correction are disclosable 14
If period in the findings are cited, an approved plan of correction is requisite to continued Except for nursing homes, the findings stated above are disclosable 90 days program participation. OCT 2 0 2023

FORM CMS-2567(02-99) Previous Versions Obsolete

SD DOH-OLC

Facility ID: 436506

If continuation sheet Page 1 of 1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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200000 5 2000	PROVIDER OR SUPPLIER REHABILITATION	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 S CLIFF AVE SIOUX FALLS, SD 57105				
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1000	with 42 CFR Part 4 485.701-485.729, Physical Therapy a Pathology services for deficiencies cit- have been correct	as conducted for compliance 485, Subpart H, Subsections requirements for Outpatient and Speech-Language s, was conducted on 11/14/23 ed on 9/28/23. All deficiencies ed, and no new noncompliance Rehabilitation was found in	100				
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIRE	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.