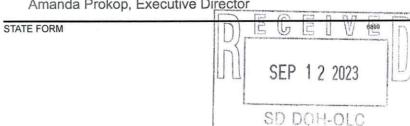
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		10746	B. WING		08/16/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
EDGEWO	OD PRAIRIE CROSSING	S WATERTOWN AL, 420 9TH ST	Г. SE WN, SD 57201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
	44:70, Assisted Living assisted living centers 8/15/23 through 8/16/Crossings Watertown compliance with the first 44:70:04:10 Tuberculin screening employees or residen (1) Each healthous shall receive an annuassessment that is domethod of tuberculin test to establish a basemployment or admisdocumented tubercul within a 12-month period prior employment is combaseline test. Skin teare not necessary if a or resident transfers the lathcare facility to a facility within this stat documentation of the testing completed with Skin testing or a TB to necessary if documentation previous positive reachealthcare employee recognized positive residend assay test shall	r compliance with the of South Dakota, Article g Centers, requirements for s, was conducted from 23. Edgewood Prairie AL, LLC was found not in ollowing requirement: S331.  Ilin screening requirements requirements for healthcare at are as follows: are employee or resident al individual TB risk ocumented and the two-step skin or a TB blood assay seline within 14 days of sision to a facility. Any two in skin tests completed riod prior to the date of ment are considered a assay test completed within for to the date of admission sidered an adequate sting or TB blood assay tests a new healthcare employee from one licensed another licensed healthcare e if the facility received last skin or blood assay TB hin the prior 12 months. Blood assay test is not not intation is provided of a control to the skin test or TB I have a medical evaluation determine the presence or	S 000	New employee's will start the T screening on their first day of employment. Onboarding for neemployee's is completed at our location IL/AL. The nursing teath this location will start the 1st state the TB screening, set up the foup for reading and will scan the document to the CSD at Edgev Prairie Crossings Watertown A location to complete the 2nd state The 2nd step to be administered after 1st step, to be completed days. ED will meet with the CS bi-weekly until December 1, 20 will then continue to monitor may in our monthly safety/QA meeting We have started implementing procedure immediately. The IL/A and LPN's, and the AL/MC CSI in this process have been involuted discussions including the requirements, and are aware on procedure. New employee's on that have had a prior TB screen show documentation of the last within a 12 month period prior of date of employment or admissing prior non-compliance for reside has been completed, late. Unable correct the prior non-compliance employees C, D, E, F, and G.	ew Sister m at ep for llow vood L ep. d 7 days in 14 D 23, and onthly ngs. this AL CSD D involved ved in f this residents ning will t testing to the on. The ent 3 ble to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Amanda Prokop, Executive Director

TITLE

(X6) DATE 9/11/2023



South Dakota Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		DENTI TOATION NOMBER.	A. BUILDING:		OOM LETED	
10746		B. WING		08/16/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		II.
EDGEWO	OD PRAIRIE CROSSING	S WATERTOWN AL,				
	CUMMADVCT		WN, SD 57201	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SHOULD BE COM	
S 331	Continued From page 1		S 331			
	met as evidenced by: Based on record review, the provider for two provider for two provider for two provider for two providers for the provider for two provides for the provided for two provides for the provided for the provide	ew, interview, and policy ailed to ensure the following: I residents (3) had a ning completed within ission. hired sampled employees ad a TB screening teen days from their hire  3's care record revealed: in 9/10/21. nentation that any type of TB				
	services director (CS TB screening reveale *Could not find docur 3's TB screening to s completed.	mentation regarding resident				
	was 28 days after shows 3. Review of employed revealed:	12/22. completed on 6/9/22, that e was hired. ee D's personnel file				
*She was hired on 5/2/23.		1				

\*Her first step TB was completed on 8/3/23.

South Da	outh Dakota Department of Health						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	FIGURE AND	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10746	B. WING		08/16/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
EDGEWOOD PRAIRIE CROSSINGS WATERTOWN AL,  420 9TH ST. SE  WATERTOWN, SD 57201							
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
S 331	Continued From page	2	S 331				
	*There was a note in her file that stated the employee was "coming in today [8/15/23] to do 2nd step"  *Her TB screening was not been completed on 8/15/22, and that was 106 days after she was hired.						
	D's TB screening reverse *Employee D had not day to have her secon administered.	SD B regarding employee ealed: come in to the facility that					
	4. Review of employe revealed: *She was hired on 1/2 *Her TB screen was of was 30 days after she	24/23. completed on 2/22/22, that					
	previous TB screening 7/21/21. *The previous TB scre						
	revealed she agreed	at 5:02 p.m. with CSD B that employee F's 7/21/21 t completed within the last nt hire date.					
	6. Review of employe revealed:	e G's personnel file					

\*He was hired on 2/2/23.

PRINTED: 08/22/2023 South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ B. WING 08/16/2023 10746 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 420 9TH ST. SE EDGEWOOD PRAIRIE CROSSINGS WATERTOWN AL, WATERTOWN, SD 57201 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 331 Continued From page 3 S 331 \*His TB screen was completed on 6/23/23 that was 142 days after he was hired. 7. Interview on 8/15/23 at 4:50 p.m. with administrator A and CSD B about the TB screenings for residents and staff revealed: \*They were both aware there were several employees and some residents who had not received their TB screening in a timely manner. \*The onboarding process for new employees began in another building, the "main building" for the provider that was where new employees completed paperwork and training their first week of employment. \*The TB screening was started after the onboarding process had been completed, when the new employee reported to the facility. \*Administrator A stated it was difficult to get the TB screening completed for new employees

8. Review of the provider's 5/2023 "Tuberculosis" policy revealed:

\*They both agreed with the above findings that TB screenings had not been completed within the

within the 14-day requirement.

specified timeframe as required.

\*"With the Licensed Nurse, or Executive Director (if applicable), health services staff is responsible for establishing and managing processes in the Community for infection control according to all regulations that apply."

\*"Staff and residents must meet designated testing and immunization requirements related to infectious diseases."

\*"The Community shall identify and fulfill the tuberculosis (TB) control and testing requirements that apply for staff and residents." \*"If a skin test is required, the Community shall administer, or coordinate for administration of, a Mantoux skin test."

PRINTED: 08/22/2023 FORM APPROVED South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING 10746 08/16/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 420 9TH ST. SE EDGEWOOD PRAIRIE CROSSINGS WATERTOWN AL. WATERTOWN, SD 57201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 331 Continued From page 4 S 331

Review of the provider's 5/2023 "TB Screening South Dakota - Employee and Resident" policy revealed: \*"Each healthcare employee or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin test within 14 days of employment or admission." \*"TB testing is not necessary if a new employee or resident transfers from one licensed healthcare facility to another within the state if the facility received documentation of the last TB testing completed within the prior 12 months."

STATE FORM

6899

If continuation sheet 5 of 5

South Dakota Department of Health

AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		10746	B. WING		09/2	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EDGEW	OOD PRAIRIE CROSS	SINGS WATERTON 420 9TH S	ST. SE DWN, SD 572	201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{S 000}	000) Compliance Statement {					
	Administrative Rule 44:70, Assisted Livi assisted living center for deficiencies cite have been correcte was found. Edgewood	compliance with the is of South Dakota, Article ing Centers, requirements for ers was conducted on 9/21/23 d on 8/16/23. All deficiencies d, and no new noncompliance and Prairie Crossings compliance with all regulations				
			-			

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

TITLE

(X6) DATE