

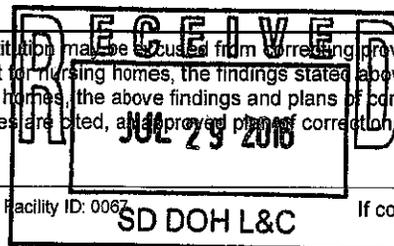
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>
---	---

(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
F 000	<p><i>*Addendums noted with an asterisk with facility administrator. 8/11/16 per telephone</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 35121 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/5/16 through 7/7/16. Prairie Estates Healthcare Community was found not in compliance with the following requirements: F252, F371, and F431.</p>	F 000		
F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and manual review, the provider failed to ensure: *Wood platforms used to hold window air conditioners were cleanable and free from paint chips in 16 of 18 resident rooms (101, 103, 104, 105, 106, 108, 109, 110, 112, 201, 202, 205, 206, 210, 213, and 214) and one of one day room. *Unused equipment had been disposed of and was not in direct view from windows in three of three resident rooms (104, 106, and 108). Findings include:</p> <p>1. Observations on 7/5/16 at 4:15 p.m. revealed in residents' rooms 101, 103, 104, 105, 106, 108, 109, 110, 112, 201, 202, 205, 206, 210, 213, and 214 there were window air conditioners. Each air conditioner had been placed on a wooden</p>	F 252	<p>F 252</p> <ol style="list-style-type: none"> <li>The wood platforms for the window air conditioners in the rooms 101, 103, 104, 105, 106, 108, 109, 110, 112, 201, 202, 205, 206, 210, 213, and 214 have been painted. The unused equipment has been cleaned up and removed and the shed has been painted.</li> <li>All residents are at risk.</li> <li>The Administrator will educate all staff no later than August 20, 2016 on reporting any paint chips or non home-like environment concerns and record such in a maintenance log to be maintained at the nurses' stations. Those not in attendance at education sessions before August 20, 2016 will be educated prior to first shift worked.</li> <li>The Administrator or designee will audit five resident rooms and all common areas each week to ensure rooms/common areas are free from paint chips, general disrepair, and unsightly outside views. Audits will be conducted weekly for four weeks and then monthly for two months. Audits will be reviewed by the Administrator at the monthly Quality Assessment Process Improvement</li> </ol>	8/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl Hallaway, Administrator</i>	TITLE	(X6) DATE 7/27/2016
--	-------	------------------------

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>		
(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	
F 252	<p>Continued From page 1</p> <p>platform. The wooden platforms had paint that had chipped away leaving bare wood and an uncleanable service.</p> <p>Observations on 7/6/16 at 1:45 p.m. revealed two window air conditioner units in the day room. Those units had wood surrounding them holding them in place. The wood had paint chips and silver tape that had come off exposing cardboard and bare untreated wood.</p> <p>2. Observation on 7/6/16 at 2:00 p.m. revealed resident rooms 104, 106, and 108 had views that looked out behind the building. There was a shed with peeling paint, two oxygen concentrators, gas cans, a scoop to a small tractor, propane tanks for a grill, and one old dumpster that were not being used. The view from those rooms had not been homelike with the unused equipment in plain sight.</p> <p>3. Interview on 7/7/16 at 2:00 p.m. with the maintenance supervisor revealed: *The day room was used for church and other scheduled activities. *He had noticed the wood platforms and the paint chips when he put the window air conditioners in place for the season. *The above items needed to be repainted. *As for the unused equipment outside residents' rooms 104, 106, and 108 there was no formal plan of when they were going to get rid of all the unused equipment.</p> <p>4. Interview on 7/7/16 at 2:15 p.m. with the administrator revealed they were aware of the unused equipment. It had come up on their pre-survey, but no formal plan had been developed to remove it from the premises.</p>	F 252	(QAPI) meeting for recommendation of continuation or discontinuation of audits.		

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

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>	
(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
F 252	Continued From page 2	F 252	F 371	
F 371 SS=D	<p>Review of the provider's undated Preventive Maintenance Manual revealed: *Room inspections should have been conducted. -It had not referenced how often. *During the room inspections staff should have checked paint, door jams, and wallpaper for damage.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, testing, and interview, the provider failed to ensure: *Water temperatures in the dishwasher were at 120 degrees Fahrenheit (F) during the wash cycle of the chemical sanitization process. *Two of two ceiling fans placed above the food prep and aboe the clean dishes area were clean. Findings include:</p> <p>1. Observation and interview on 7/6/16 at 12:20 p.m. with dietary assistant B revealed: *They utilized a low temperature wash and chemical sanitizer process.</p>	F 371	<p>1. The dishes are being washed at a temperature of at least 120 degrees F. The two ceiling fans have been cleaned and new ceiling fans have been ordered and will be installed upon receipt.</p> <p>2. All residents are at risk.</p> <p>3. The Dietary Manager will educate dietary staff no later than August 20, 2016 on the following procedure: To ensure the optimal washing temperature of the dishwasher be at 120 degrees, staff will run the dishwasher prior to loads of dishes being washed to get the temperature of the wash water to at least 120 degrees F before washing the dishes. Further education will include to ensure ceiling fans are cleaned in their entirety on scheduled cleaning days. Those not in attendance at education sessions prior to August 20, 2016 will be educated prior to first shift worked.</p> <p>4. The Dietary Manager or designee will review the dishwasher temperature log daily and audit dishwashing temperatures at random times five times a week to ensure the water temperature is at least 120 F.</p>	8/25/16

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

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>		
(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	
F 371	<p>Continued From page 3</p> <p>*During the first load of dishes through the dishwasher the water temperature registered at 96.5 degrees F.</p> <p>*She stated she usually recorded the water temperature after the last load of dishes had been run through and not at the beginning.</p> <p>Observation and interview on 7/7/16 at 9:30 a.m. with the dietary manager and dietary assistant B revealed:</p> <p>*The wash water temperature for the first load of dishes through the dishwasher was 101 degrees F.</p> <p>*For the second load the water temperature was 105 degrees F.</p> <p>-Both times the computerized indicator turned red and said "low wash temperature."</p> <p>*After the third load of dishes had been sent through the dishwasher the water temperature registered above 120 degrees F.</p> <p>*The dietary manager knew the water temperature should have been at 120 degrees F.</p> <p>*Dietary assistant B would not have run the first two loads through again since the sanitizer had gone through them.</p> <p>*They stated sometimes the water temperature took longer to heat up depending on what else was going on in the building.</p> <p>*The chemical sanitizer had registered at the correct parts per million when tested by dietary assistant B.</p> <p>A policy was requested but was not provided by the time the survey team exited the facility.</p> <p>2. Observations on 7/5/16 at 2:30 p.m. and on 7/6/16 at 11:30 a.m. revealed two ceiling fans in the kitchen. One ceiling fan was directly above the clean dishes. The other ceiling fan was above</p>	F 371	<p>Additionally, the cleanliness of ceiling fans will be audited weekly. Audits will be conducted weekly for four weeks and then monthly for two months. Audits will be reviewed by the Dietary Manager at the monthly QAPI meeting for recommendation of continuation or discontinuation of audits.</p>		

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

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>	
(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
F 371	Continued From page 4 the food preparation area. The ceiling fans had dark gray matter on the top of the blades and strings of dust hanging from the motors and other areas of the fan.  Observation and interview on 7/7/16 at 9:30 a.m. with the dietary manager and dietary assistant B revealed dietary assistant B used a duster on the fan blades about once a week. She had used the degreaser on the blades, but the ladder provided to her was short. It did not allow her to see above the blades to know if they were clean or not. The dietary manager agreed both fans needed to be cleaned.	F 371	F 431  1. There are no Fentanyl patches in use, nor were there any in use at the time of survey.  2. All residents with Fentanyl patches are at risk.  3. The Director of Nursing (DON) will educate all nurses on the policy for Destruction of a Fentanyl patches which includes: Destruction of Fentanyl patches will be completed by 2 nurses witnessing the disposal of the used/unused patch being placed in the RX destroyer bottle. Education will occur no later than August 20, 2016. Those nurses not in attendance at education sessions prior to August 20, 2016 will be educated prior to first shift worked.	8/25/16
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	4. The DON will audit the destruction of Fentanyl patches to ensure they are destroyed per policy. Audits will be weekly for four weeks and then monthly for two months. Audits will be reviewed by the DON at the monthly QAPI meeting for recommendation of continuation or discontinuation of audits.  <i>*Audits will begin at the time any resident has a fentanyl patch in use. MUSDOTTJEL</i>	

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

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>		
(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	
F 431	<p>Continued From page 5</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and procedure review, the provider failed to destroy fentanyl (a narcotic pain medication) patches in a secured manner. Findings include:</p> <p>1. Observation and interview on 7/5/16 at 6:00 p.m. with registered nurse (RN) A regarding destruction of used fentanyl patches revealed: *She had worked here for two years. *She was the full time day nurse. *No residents were currently on a fentanyl patch, but one resident recently had been. *Fentanyl patches were destroyed by: -Two nurses who would sign off the used patches on a destruction form. -Placing them in the locked sharps container on the side of the medication cart. *That sharps container would then be placed in an unlocked container in the utility room until it was picked up for disposal. -That room was observed to have a key pad lock on the door that all staff had access to. -It would have been easy to access the fentanyl</p>	F 431			

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

PRINTED: 07/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>
---	---

(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
--------------------	--	---------------	---	----------------------

F 431	<p>Continued From page 6 patches for possible abuse.</p> <p>Interview on 7/7/16 at 1:25 p.m. with the director of nursing regarding the fentanyl patch destruction revealed she agreed RNA should have been aware of the procedure to destroy the used patches.</p> <p>Review of the undated provider's Administration &amp; Disposal of Fentanyl Patches procedure revealed:                      ***Fentanyl disposal: two nurses should witness the disposal of used/unused patches. Patches are to be placed in RX destroyer."                      ***Both nurses would sign on Narc record that removed patch was destroyed."</p>	F 431		
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	---	---	---

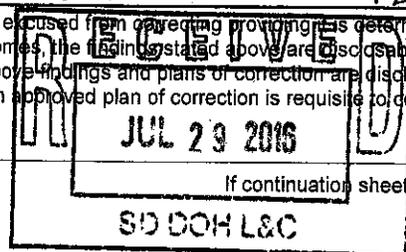
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>
---	---

(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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/7/16. Prairie Estates Healthcare Community was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

*Cheryl Hallaway* *Administrator* *7/27/16*

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.



**ORIGINAL**

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 S FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement  Surveyor: 35121 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/5/16 through 7/7/16. Prairie Estates Healthcare Community was found not in compliance with the following requirement: S206 and S293.	S 000	S 206  1. No immediate correction could be taken. Prior to August 20, 2016, all Staff will be educated on <ul style="list-style-type: none"> <li>• Accident prevention and safety procedures pertaining to resident safety</li> <li>• Diseases subject to mandatory reporting</li> <li>• Care of residents with unique needs.</li> </ul>	8/25/16
S 206	44:73:04:05 Personnel Training  The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment.  Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	2. All residents are at risk.  3. The Administrator has been educated on education requirements at the time of survey and will ensure an ongoing education program will cover the required subjects annually.  4. All staff will have the missing training no later than August 20, 2016. Those staff missing education sessions will receive training prior to their first shift worked. The administrator will audit all staff's education records to ensure training has been completed and then going forward will audit all new employees weekly to ensure the required education is completed. Audits will continue for four weeks and then monthly for two months Audits will	

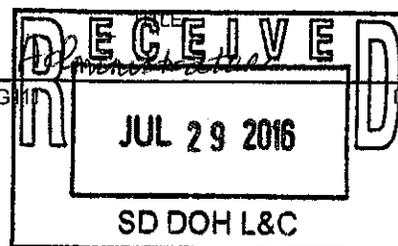
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Cheryl Hallaway*

STATE FORM 0

8899

7LG



(X6) DATE

7/27/16

continuation sheet 1 of 4

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 S FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35121</p> <p>Based on record review, and interview, the provider failed to ensure all staff had annual training for 3 of 11 mandated annual topics (accident prevention and safety procedures, diseases subject to mandatory reporting, and care of residents with unique needs). Findings include:</p> <p>1. Review of the provider's 2015 annual training records revealed there was no documentation training had been provided for all staff for the following topics: *Accident prevention and safety procedures. *Diseases subject to mandatory reporting. *Care of residents with unique needs.</p> <p>Interviews on 7/7/16 at 10:30 a.m. and at 1:15 p.m. with the director of nursing (DON) and the administrator confirmed: *There had been residents with unique needs including diabetes, Down Syndrome, hospice, and dialysis. *No annual training had been provided to all staff regarding the following topics: -Accident prevention and safety procedures. -Diseases subject to mandatory reporting. -Care of residents with unique needs. *Each department head was responsible to provide required annual training for their staff. *Their expectation was all employees should have received all the mandated training according to the regulation.</p> <p>Interview on 7/7/16 at 1:30 p.m. with the</p>	S 206	<p>be reviewed by the Administrator at the monthly QAPI meeting for recommendation of continuation or discontinuation of audits.</p>	
-------	---	-------	--	--

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE ESTATES HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 S FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	Continued From page 2 administrator revealed the provider did not have a policy on employee training.	S 206	S 293	
S 293	<p>44:73:07:08 Written Dietetic Policies</p> <p>There shall be written policies and procedures that govern all dietetic activities. Policies shall include food handling procedures, length of duration for leftovers, and opened packages of commercially prepared food in accordance with chapter 44:02:07, the Food Service Code. Policies and procedures shall be reviewed yearly and revised as necessary.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and policy review, the provider failed to follow their policy and use diet cards during two of two observed meal services. Findings include:</p> <p>1. Observation on 7/5/16 of cook C from 5:45 p.m. through 6:15 p.m. revealed she had not used the diet cards to dish up the residents' meals.</p> <p>Observation on 7/6/16 of dietary assistant B from 11:45 a.m. through 12:15 p.m. revealed she had not used the diet cards to dish up the residents' meals.</p> <p>Interview on 7/7/16 at 9:00 a.m. with the dietary manager revealed they did not use the diet cards. They had not filled out likes or dislikes to know what the residents would have preferred.</p> <p>Review of the provider's undated Tray I.D. Cards policy revealed:</p>	S 293	<p>1. No immediate correction could be taken. All residents will have diet cards no later than August 25, 2016.</p> <p>2. All residents are at risk.</p> <p>3. The Dietary Manager has reviewed the policy and will ensure diet cards are made for each of the residents and will contain:</p> <ul style="list-style-type: none"> <li>- Resident Name</li> <li>- Room Number</li> <li>- Diet Order</li> <li>- Beverage Preference</li> <li>- Food Dislikes</li> <li>- Any Other Diet Information</li> <li>- Food Allergies Written in Red</li> </ul> <p>No later than August 20, 2016 the Dietary Manager will educate all dietary personnel on the requirement to use diet cards for all meals. Those not in attendance in education sessions prior than August 20, 2106 will be educated on the first shift worked.</p> <p>4. The Dietary Manager or designee will audit five random meals per week to ensure diet cards are in use and followed during meal service. Audits will be weekly for four weeks and then monthly for two months. Audits will be reviewed by the</p>	8/25/16

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/07/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER: **PRAIRIE ESTATES HEALTHCARE COMMUNITY**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **600 S FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 293	Continued From page 3  *The dietary manager should have met with a new resident on admission to obtain food and beverage preferences. *A permanent diet card should have contained the following: -Resident's name. -Room number. -Diet order. -Beverage preference. -Food dislikes. -Any other diet information. -Food allergies should have been written in red. *Diet cards should have been used during meal service to ensure the correct diet was being served and food preferences were honored. *The dietary manager was responsible for keeping the diet cards up-to-date.	S 293	Dietary Manager at the monthly QAPI meeting for recommendation of continuation or discontinuation of audits.	
S 000	Compliance/Noncompliance Statement  Surveyor: 35121 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 from 7/5/16 through 7/7/16. Prairie Estates Healthcare Community was found in compliance.	S 000		