F 000 INITIAL COMMENTS

Surveyor: 35237
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/24/19 through 6/28/19. Prairie Heights Healthcare was found not in compliance with the following requirements: F561, F610, F679, F744, and F758.

F 561 Self-Determination
SS=D
CFR(s): 483.10(f)(1)-(3)(8)

§483.10(f) Self-determination.
The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not

ABANDONED PLAN OF CORRECTION FOR F342

The statement on this plan of correction is not a submission to and do not constitute an agreement with the alleged deficiency herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assurance of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.

F 561
1) Resident #52 informed therapy starts at 6:30am. Inquired what time she would like to start her therapies in the morning/consent signed. Therapy schedule for resident #52 adjusted to accommodate preference. Completed 7/12/19.

2) Will do follow up with all in house residents who are currently on therapy to inform them therapy start time is 6:30am. If they are not ok with starting therapies at 6:30am, will inquire what time they would be ok with starting therapies for the day. Will adjust therapy times to accommodate preferences. Consents will be signed with all in house residents receiving therapy. This will be completed by 7/17/19.

3) Going forward with future resident's morning therapy schedule, when therapy orders are obtained, evaluating therapist will educate residents about therapies starting at 6:30am, if the resident requests an alternate time for start, will be accommodated to when making therapy schedules.

4) Director of rehab will educate all therapy staff on the above process by 7/22/19.

5) Director of rehab/designee will audit 10 residents/week for a total of 4 weeks to validate preference of therapy start time is being accommodated. QAPI meets monthly, audits will be brought to meeting for reviews by the QAPI team. At this time a decision will be made for the audits to either continue or be resolved.

Signature:
Darcy Albrecht
Administrator
7/26/19

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 discolosable 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 discolosable 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**

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<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F561 | Continued From page 1  
interfere with the rights of other residents in the facility. 
This REQUIREMENT is not met as evidenced by: 
Surveyor: 35237  
Based on observation, interview, record review, and admission packet review, the provider failed to ensure one of one sampled resident's 52 choices related to her therapy schedule had been followed. Findings include:  
1. Review of resident 52's medical record revealed: 
*She had been admitted on 5/7/19.  
*She was alert and oriented.  
*Her 5/14/19 admission Minimum Data Set assessment regarding her daily preferences revealed: 
--It was very important for her to choose her own bedtime. 
--There was no question to specifically address how important her wake-up time would have been.  
*Her 6/26/19 care plan revealed:  
-"Involve [resident name] in IDT [interdisciplinary team] and care planning."  
-"Allow patient to perform tasks at his or her own rate. Do not rush patient. Encourage independent activity as able and safe."  
Observation and interview on 6/24/19 at 4:56 p.m. with resident 52 in her room revealed:  
*She was sitting in her bed reading a book.  
*She had been admitted about five weeks ago following a fall at home when she broke her hip.  
*She was working with therapy services and hoping to get back home soon.  
*Her only complaint was having to get up so early in the morning for therapy sessions. |
**F 561** Continued From page 2

*She was not a morning person and did not feel well at that time of the day.*
- She further stated she used to have low blood pressure issues early in the morning.
*The white dry erase board in her room indicated she would have three therapy appointments the next day at the following times:*
- At 6:30 a.m. with occupational therapy (OT).
- At 8:30 a.m. with physical therapy (PT).
- At 12:00 noon with speech therapy (ST).
*She had told more than one therapy staff person that she did not like those early morning appointments, and they still scheduled her that way at times.*

Observation and interview on 6/25/19 at 9:05 a.m. with resident 52 in her room revealed:
*She had just returned from therapy and was sitting in her wheelchair.*
*She had slept well the night before, and therapy had gone okay that morning.*
*Her preference still would have been to not do therapy so early in the morning.*

Observation on 6/26/19 at 8:29 a.m. of the dry erase board in resident 52's room revealed her three therapy appointments for that day were at the following times:
*At 8:00 a.m. with OT.*
*At 12:00 noon with PT.*
*At 1:35 p.m. with ST.*

Interview on 6/28/19 at 8:45 a.m. with the social services designee regarding resident 52's concern with her therapy schedule revealed:
*She had not been aware of the resident not wanting her therapy appointments so early in the morning.*
*If the resident had told staff she had not wanted...*
F 561 Continued From page 3

therapy scheduled so early in the morning her preference for that should have been followed.

Interview on 8/26/19 at 8:49 a.m. with the director of rehabilitation (rehab) services regarding resident 52 revealed:
*He had known her for awhile, since she had been a resident in the facility for a separate stay prior to this admission.
*He was aware she did not like her therapy appointments early in the morning.
*Sometimes OT was scheduled at 6:30 a.m. in order to work on specific exercises such as dressing in order to get it done before breakfast started at 7:30 a.m.
*He thought the resident only had one or two times when therapy had been scheduled for 6:30 a.m. since she had been admitted.

Interview on 8/26/19 at 9:34 a.m. with the director of nursing regarding resident 52's therapy schedule revealed:
*She expected the resident's therapy schedule to be adjusted and meet the resident's preferences.
*Therapy staff could have accommodated the resident's preferences to not be scheduled early in the morning.

Further interview and record review on 8/26/19 at 10:03 a.m. with the director of rehab regarding resident 52 revealed:
*He brought her 5/7/19 through 6/26/19 therapy scheduled appointments list for review.
*According to that list she had been scheduled for the 9:30 a.m. time on the following dates:
- On 5/10/19 with PT.
- On 5/24/19 with OT.
- On 5/27/19 with PT.
- On 8/14/19 with PT.
Continued From page 4

-On 6/17/19 with PT.
-On 6/25/19 with OT.

*He stated she was getting three different therapies five days a week, and it could be difficult to get them all fit in during the day.
*He confirmed they could have adjusted her therapy schedule to meet her preferences.
*They could have worked on dressing at the time of her shower or asked her when it worked best for her to work on those dressing exercises.

Interview on 6/26/19 at 10:27 a.m. with registered nurse/unit manager A regarding the above for resident 52 revealed:

*She was the unit manager for the rehab unit.
*Therapy appointments were scheduled by the therapy staff.
*She confirmed therapy appointments should have been scheduled to accommodate the resident's preferences.

Review of the provider's revised July 2018 Resident Admission packet revealed:

"...The rehab gym and office hours of operation are Monday through Friday 6:40 AM to 4:30 PM and Weekends by appointment only. Our therapy sessions are conducted one on one with the resident..."

"The inter-disciplinary team or IDT, consists of your individual case manager, therapist(s), social services, dietary, recreation and direct care supervisor. Resident and/or family participation in our IDT meetings is extremely important and highly encouraged..."

*The resident had a right to choices including:

"(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being, and
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER:**

A. Building: 435004

B. Wing: 

**NAME OF PROVIDER OR SUPPLIER:**

PRAIRIE HEIGHTS HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

408 8TH AVENUE NW

ABERDEEN, SD 57401

**DATE SURVEY COMPLETED:**

06/26/2019

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<th>(DD) COMPLETION DATE</th>
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| F 561 | Continued From page 5 -(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participated in planning care and treatment or changes in care and treatment."

F 610 | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Surveyor: 35237

Surveyor: 40772

Based on interview, record review, and policy review, the provider failed to thoroughly investigate an incident for one of one sampled resident (47) who had a fall with a head injury. Findings include:

1. Review of resident 47’s medical record revealed:

   a. She was admitted on 5/29/12.
### F 610

Continued From page 6  

*Her Brief Interview for Mental Status (BIMS) assessment score was an eleven indicating her cognition was moderately impaired.  
*She required the extensive assistance of two staff members for bed mobility.  
*On 5/5/19 she had rolled out of bed.

Review of resident 47's fall investigation from 5/5/19 revealed:  
*She fell out of bed.  
*Positioning pillows were discontinued on 12/26/19 due to limited mobility.  
*The staff that were present had been interviewed.  
--She had been provided incontinent care at 3:00 a.m.  
--They had been in her room at 4:00 a.m.  
--She was found on the floor at 4:15 a.m.  
--Her bed was damp, and she was wet with urine.  
*The investigation did not indicate the resident's position in the bed fifteen minutes prior to the fall.

Interview on 6/26/19 at 8:28 a.m. with the director of nursing (DON) revealed she felt if a resident was asked immediately following an incident regardless of their BIMS score they could tell you what happened.

Interview on 6/26/19 at 8:33 a.m. with registered nurse E, the director of nursing, and the administrator regarding resident 47's 5/5/19 fall revealed:  
*She was taken at her word for how she fell out of bed.  
*It was not investigated how the resident was positioned in her bed prior to the fall.  
--If she had been near the edge of the bed when staff were in the room fifteen minutes prior to the fall it was the expectation she would have been...
F 610  Continued From page 7
repositioned.
-They agreed what the resident was doing prior to a fall could be added to their investigation form.
-There were no other interventions evaluated prior to the implementation of the positioning pillows.
-They did not know what had caused the fall.

Review of the provider's 2018 Assessing Falls and Their Causes policy revealed:
"The purposes of this procedure are to provide guidelines for evaluating/gathering data on a resident after a fall and to assist staff in identifying causes of the fall."  
"Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident."  
"Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found."

F 679  Activities Meet Interest/Needs Each Resident
SS=D

CFR(s): 483.24(c)(1)

§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:
Surveyor: 40772
Based on observation, interview, record review, and policy review, the provider failed to ensure
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<tr>
<td>F 679</td>
<td>Continued From page 8 one of two sampled residents (47) had individualized and meaningful activities offered and documented. Findings include: 1. Review of resident 47’s 12/14/18 annual Minimum Data Set assessment revealed: *She was admitted on 5/29/12. *Her Brief Interview for Mental Status assessment score was an eleven, indicating her cognition was moderately impaired. *She nor her family could be interviewed regarding her preferences. *The staff assessment of preferences was completed and revealed her preferences were: -Reading books or magazines. -Listening to music. -Being around animals. -Doing things in groups. -Participating in her favorite activities. -Spending time outdoors. Interview with resident 47 on 6/24/19 at 4:13 p.m. revealed: *She laid in her bed and watched TV during the day. *She liked to go to BINGO. Observations of resident 47 on 6/24/19 from 4:10 p.m. through 7:15 p.m., on 6/25/19 from 7:30 a.m. through 6:45 p.m., and on 8/26/19 from 7:30 a.m. through 3:00 p.m. revealed: *She was in her room in her bed. *She was in her room in her wheelchair. *Her TV was on at times. *She went to the dining room for meals. Review of resident 47’s 6/25/19 care plan revealed: *She was receptive to:</td>
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<td>1) Recreational/therapeutic assessment was completed on resident #47 on 7/17/19. 2) Resident #47 interest likes will be placed on careplan and CNA kardox to encourage resident attendance. WILL OFFER AND DOCUMENT AT MINIMUM 3X/WEEK RESIDENTS PREFERRED/LIKED ACTIVITIES. 3) Administrator will educate activity department on need to complete recreational therapeutic assessment upon admission then annually an updated recreational assessment with resident likes/interests added to resident careplan/kardox. Also educated on need to document attendance/decline of activities. ACTIVITIES ATTENDANCE LOG WILL BE DIVIDED INTO HALLWAYS AND 1 THAT WILL SHOW ACTIVITY OFFERED AND ACCEPTANCE/DECLINE OF SAME. ACTIVITY DIRECTOR OR DESIGNEE WILL REVIEW ATTENDANCE LOG 3X/WEEKLY TO ENSURE DOCUMENTATION IS COMPLETE. 4) All residents have the potential to be affected-activity department will complete an updated recreational quarterly assessment with ALL RESIDENTS likes/interests added to careplans/CNA kardox by 7/31/19. 5) Assessment will be completed upon admission WITH ALL RESIDENTS then annually thereafter with obtained likes/interests added to the careplan and kardox. 6) Activity director/designee will educate nurse aides on need to encourage resident activity attendance AT MINIMUM OF 3X/WEEK per listed likes/interests on kardox by 7/25/19. 7) Activity director or designee will audit 5 residents/week to ensure has up to date recreational therapeutic assessment with likes/interests present on careplan/CNA kardox and these residents have documented attendance/decline of activities. 8) OAPI meets monthly. Audits will be brought to meeting for reviews by the OAPI team. At this time a decision will be made for the audits to either continue or to be resolved.</td>
<td>F 679</td>
<td>8/9/19</td>
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<td>-Music.</td>
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<td>-Watching TV, specifically channel 25.</td>
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Review of resident 47's activity logs revealed:
*In April 2019 she was not offered activities eleven of thirty days.
-On four other days she was only offered the leisure cart and refused it.
*In May 2019 she was not offered activities on eight of thirty-one days.
-On five other days she was only offered the leisure cart and refused it.
*In June 2019 she had not been offered activities twelve out of twenty-five days.
-On six other days she had only been offered leisure cart and refused it.

Interview on 6/26/19 at 9:14 a.m. with the activity director revealed:
*The leisure cart served a dual purpose that was to promote hydration and one-to-one visits with residents.
*There was no set amount of time she spent with residents.
*If residents needed assistance with hydration she could spend up to ten minutes in the room.
*There was no assessment for determining resident needs for activities.
*There was no criteria for one-to-one visits.
*Resident 47 went to music activities and stayed in her room.
*She indicated resident 47 was visited weekly by a dog that came to the facility.
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<td>- Documentation showed she was visited by the dog one of four weeks in April, three of four weeks in May, and zero of four weeks in June.</td>
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<td>- She agreed it should have been documented when activities were refused.</td>
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<td>Review of the provider's undated Activity Programs policy revealed: &quot;Activity programs designed to meet the needs of each resident are available on a daily basis.&quot;</td>
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<td>Review of the provider's undated Individual Activities and Room Visits Program policy revealed:</td>
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<td><strong>&quot;Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities.&quot;</strong></td>
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<td><strong>&quot;Typically a room visit is ten to fifteen minutes in length.&quot;</strong></td>
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<td>Review of the provider's 2018 Charting and Documentation policy revealed: &quot;All services provided to the resident, progress towards care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.&quot;</td>
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<td>Treatment/Service for Dementia</td>
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<td>55-50</td>
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<td>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced.</td>
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<td>F 744</td>
<td>Continued From page 11</td>
<td>by: Surveyor: 40772 Based on observation, interview, record review, and policy review, the provider failed to ensure one of four sampled residents (69) who had dementia and behaviors had received appropriate interventions and documentation to support her psychosocial well-being. Findings include:</td>
<td>1) Resident #69 will have behavior/intervention flow record implemented. Tool will be utilized to document behaviors and non-pharmacological intervention used prior to using PRN medications for behaviors. Will also use tool when considering adjustments of any anti-psychotic, anti-depressant, anti-seizure and/or hypnotic medications. Resident will have care-planned non-pharmacological interventions added to CNA kardex under mood/behavior category for their reference when resident is having behaviors for them to try. These interventions will also be added to the behavior/intervention flow records for professional nurse reference/use prior to using PRN medication. This will be completed by 7/19/19. *All residents on PRN/scheduled psychotropic meds have the potential to be affected, will proceed with the following:</td>
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Review of resident 69's nursing progress notes from December 2018, January 2019, and June 2019 revealed: *In December 2018 she had eighteen of thirty-one days where yelling out behaviors were documented. -Of those eighteen days seven days indicated a non-pharmacological intervention was attempted. *In January 2018 eighteen of thirty-one days there were yelling behaviors documented. -Of those eighteen days two days indicated a non-pharmacological intervention was attempted. *In June 2019 she had one of twenty-five days with documentation of yelling out behaviors. -On that day a non-pharmacological intervention was used and was successful.
Review of resident 69's 6/26/19 care plan revealed:
*Seven of eleven interventions for anxiety were implemented on 2/26/19.
*Interventions included:
  - "Administer medication per physician orders
    Ativan is scheduled and PRN [as needed]. Try
    non-pharmacological interventions on her; offer
    the bathroom, offer something to eat and drink,
    monitor her health status/pain, try and redirect
    her to an activity in her room or in a group setting.
    She does like to watch TV sometimes."
  - "Evaluate effectiveness and side effects of
    medications for possible decrease/elimination of
    psychotropic drugs PRN."
  - "Identify and decrease environmental stressors."
    --Initiated 6/13/18.
  - "Offer 1:1 conversation."
  - "Offer snacks of her liking."
  - "Offer talking books/headphones/MP3 player of
    her favorite music."
  - "Offer to turn her air conditioner on when she
    states she is too warm or states she can't
    breath."
  - "Psych consult and treatment."
  - "Recruit and encourage attendance at activities."
  - "Utilize essential oil diffuser in her room with oils
    when she requests."
  - "Ensure that her hand held fan is within reach."
    --Initiated 2/26/19.

Interview on 6/28/19 at 2:40 p.m. with certified
nursing assistants C and D regarding resident 69
revealed:
*She was used to having someone in her room
with her.
*She got lonely in her room and called out.
*She typically did not know what she needed but
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<th>ID</th>
<th>PRECISION TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PRECISION TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 744 | Continued From page 13 | wanted people to sit with her in her room.  
*She liked when staff sat with her.  
*She had two or three people who could come and sit with her during the day.  
*They would explain to her she needed to use her call light and not yell out.  
*Sometimes they would turn on her music or TV.  
Resident 69 had not received appropriate dementia care and services to meet her behavioral and psychosocial needs. Refer to F758 finding 1. | F 744 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) | §483.45(e) Psychotropic Drugs.  
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  
(i) Anti-psychotic;  
(ii) Anti-depressant;  
(iii) Anti-anxiety; and  
(iv) Hypnotic  
Based on a comprehensive assessment of a resident, the facility must ensure that---  
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  
§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically | F 758 |

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LEA YEAR 2019  
FACILITY NO.: 0033  
EVENT ID: 6U2F11  
F082019  
If continuation sheet Page 14 of 19
F 758 Continued From page 14
contraindicated, in an effort to discontinue these

drugs;

§483.45(e)(3) Residents do not receive
psychotropic drugs pursuant to a PRN order
unless that medication is necessary to treat a
diagnosed specific condition that is documented
in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs
are limited to 14 days. Except as provided in
§483.45(e)(5), if the attending physician or
prescribing practitioner believes that it is
appropriate for the PRN order to be extended
beyond 14 days, he or she should document their
rationale in the resident's medical record and
indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic
drugs are limited to 14 days and cannot be
renewed unless the attending physician or
prescribing practitioner evaluates the resident for
the appropriateness of that medication.

This REQUIREMENT is not met as evidenced by:
Surveyor: 40772

Based on observation, interview, record review,
and policy review, the provider failed to ensure
one of four sampled residents (69) had
appropriate documentation to support the
rationale for adding and increasing psychotropic
medications. Findings include:

1. Review of resident 69's medical record
revealed:

*She was admitted on 6/1/19.

*Her Brief Interview for Mental Status
assessment score was a ten indicating her
cognition was moderately impaired.

F 758

1) Resident #69 will be added to behavior charting when
there is noted increase, worsening, lack of improvement or
change in behaviors that would require an update to the
MD with a potential request for a change in her
psychotropic medication. There will need to be 5 days of
consistent charting that would support the update and the
request in the change of medications, this would include
behaviors and non-pharmacological interventions that had
been tried.

*There is no correction that can be put into place on
previous psychotropic med changes on resident #69.

*All residents on PRN/scheduled psychotropic meds have
the potential to be affected, will proceed with the following:

2) Will do an audit of all in house residents on PRN and
scheduled psychotropic medications. Will place residents
on behavior charting PRN when behaviors increase,
worst, do not improve or change and request for a
change in the psychotropic med may be indicated. Will
have 5 consistent days of charting that document behaviors
and interventions that would be supportive to an update to
the MD and request in the change of the psychotropic
medication prior to the request being made. This will be
completed by 7/25/19.

3) Going forward with future residents on PRN and
scheduled psychotropic medications. Will place residents
on behavior charting PRN when behaviors increase,
worst, do not improve or change and request for a
change in the psychotropic med may be indicated. Will
have 5 consistent days of charting that document behaviors
and interventions that would be supportive to an update to
the MD and request in the change of the psychotropic
medication.

4) DON or designee will educate all professional nurses on
the implementation of the behavior charting when
resident's behaviors increase, worsen, do not improve or
change and request for a change in the psychotropic med
may be indicated. Will have 5 consistent days of charting
that document behaviors and attempted
non-pharmacological interventions that would be supportive
to an update to the MD and request in the change of the
psychotropic medication. This will be completed by 7/25/19.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| F 758 | Continued From page 15 | *Her diagnoses included:  
- Shortness of breath.  
- Congestive heart failure.  
- Major depressive disorder recurrent.  
- Anxiety disorder unspecified.  
- Dementia in other disease classified elsewhere with behavioral disturbance.  
  
Observation and interview on 6/24/19 at 4:40 p.m. with resident 69 revealed:  
*She liked the facility.  
*The staff were nice to her.  
*She did not display any signs or symptoms of anxiety during the interview.  
  
Random observations of resident 69 on 6/25/19 from 7:30 a.m. through 6:45 p.m. and on 6/28/19 from 7:30 a.m. through 4:00 p.m. revealed:  
*She was sitting in her room in her wheelchair.  
*Visitors were playing cards with her at times.  
*Her essential oil diffuser was on at times.  
*No yelling out was noted.  
  
Review of all of resident 69's nursing progress notes from December 2018, January 2019, and June 2019 revealed:  
*In December 2018 she had eighteen of thirty-one days where yelling out behaviors were documented.  
- Of those eighteen days, seven days indicated a non-pharmaceutical intervention was attempted.  
*In January 2019 eighteen of thirty-one days there were yelling behaviors documented.  
- Of those eighteen days, two days indicated a non-pharmaceutical intervention was attempted.  
*In June 2019 she had one of twenty-five days with documentation of yelling out behaviors.  
- On that day a non-pharmaceutical intervention was used and was successful. | F 758 | 06/28/2019 |
F 758 Continued From page 16

Review of resident 69's medication administration records revealed:
* On 12/26/19 Abilify 2.5 milligrams (mg) was added at bed time for anxiety.
* On 6/13/19 the Abilify was increased to 2.5 mg twice daily.
* She was also receiving scheduled and as needed Ativan.

Review of resident 69's 6/26/19 care plan revealed:
* Seven of eleven interventions for anxiety were implemented on 2/26/19.
  * Those were two months after the Abilify had been started.
  * Interventions included:
    * "Administer medication per physician orders Ativan is scheduled and PRN [as needed]. Try non-pharmacological interventions on her; offer the bathroom, offer something to eat and drink, monitor her health status/pain, try and redirect her to an activity in her room or in a group setting. She does like to watch TV sometimes."
    * "Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs PRN."
    * "Identify and decrease environmental stressors."
      * Initiated 6/13/18.
    * "Offer 1:1 conversation."
    * "Offer snacks of her liking."
    * "Offer talking books/headphones/MP3 player of her favorite music."
    * "Offer to turn her air conditioner on when she states she is too warm or states she can't breathe."
    * "Psych consult and treatment."
    * "Recruit and encourage attendance at activities."
    * "Utilize essential oil diffuser in her room with oils..."
Continued From page 17 when she requests"
-"Ensure that her hand held fan is within reach."
-Initiated 2/26/19.

Interview on 6/26/19 at 10:33 a.m. with registered nurse E and the administrator regarding resident 69 revealed:
*She had anxiety.
*She yelled out when people were not with her.
*She was typically okay when people were with her.
*Some of the interventions for her anxiety were implemented after she had started the Ability.
*She had an order for Ativan when she was experiencing breakthrough anxiety.
*Her family knew she did better when people were with her, and they had hired two individuals to be with her in the afternoons.

Interview on 6/26/19 at 2:40 p.m. with certified nursing assistants C and D regarding resident 69 revealed:
*She was used to having someone in her room with her.
*She got lonely in her room and called out.
*She typically did not know what she needed but wanted people to sit with her in her room.
*She liked when staff sat with her.
*She had two or three people who could come and sit with her during the day.
*They would explain to her she needed to use her call light and not yell out.
*Sometimes they would turn on her music or TV.

Review of the provider's 2018 Antipsychotic Medication Use policy revealed: "Antipsychotic medications may be considered for residents with dementia but only after medial, physical, functional, psychological, emotional psychiatric,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/OLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>435004</td>
<td>A. BUILDING</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>B. WING</td>
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</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**PRAIRIE HEIGHTS HEALTHCARE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

400 8TH AVENUE NW
ABERDEEN, SD 57401

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
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<tr>
<th>ID PREFIX</th>
<th>TAG</th>
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<tbody>
<tr>
<td>F 758</td>
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</tbody>
</table>

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
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<tr>
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<tbody>
<tr>
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</tbody>
</table>

Continued From page 18 
social and environmental causes of behavioral symptoms have been identified and addressed."
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td></td>
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</table>

Surveyor: 35237
A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 6/24/19 through 6/28/19. Prairie Heights Healthcare was found in compliance.

Administrator 7/18/19
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X8) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td></td>
<td><strong>INITIAL COMMENTS</strong></td>
<td>K 000</td>
<td></td>
<td>Aberdeen Plan of Correction for Annual Life Safety Code Survey of June 25, 2019.</td>
<td>8/9/19</td>
</tr>
</tbody>
</table>
|         |            | Surveyor: 40506  
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/25/19. Prairie Heights Healthcare (main building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  
The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K226 in conjunction with the providers commitment to continued compliance with the fire safety standards. |         |            | 1) The top latching hardware on the door leaf of the cross-corridor door adjacent to rooms 161 and 162 was adjusted on 6/25/19 by the maintenance director so door did latch.  
2) Maintenance Director will audit the door latch of the cross-corridor door adjacent to rooms 161 and 162.5x/week for 8 weeks to ensure the latch is functioning properly.  
3) QAPI meets monthly; audits will be brought to meeting for review by the QAPI team. At this time a decision will be made to either continue or be resolved. |         |
| K 226   |            | **Horizontal Exits**                                                                                  | K 226 |            |  
Horizontal Exits  
Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4.  
18.2.2.5, 19.2.2.5  
Horizontal Exits  
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18.2.2.5, 19.2.2.5  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 40506  
Based on observation and interview, the provider failed to maintain the two hour fire resistive rating of horizontal exits. The top latching hardware on one door leaf of the cross-corridor doors adjacent to rooms 161 and 162 was not functioning properly. Findings include:  
1. Observation at 10:35 a.m. on 6/25/19 revealed | 8/9/19 |
<p>| SS-D    |            | <strong>CFR(s): NFPA 101</strong>                                                                                  |         |            | |</p>
<table>
<thead>
<tr>
<th>ID: K 226</th>
<th>Enumerated缺陷</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued From page 1</td>
<td>the top latching hardware installed on the east leaf in the pair of ninety-minute fire-rated cross-corridor doors adjacent to rooms 161 and 162 did not latch. Interview with the maintenance director at the time of the observation confirmed that hardware did not latch.</td>
<td>(Each corrective action should be cross-referenced to the appropriate deficiency)</td>
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<tr>
<td></td>
<td>This deficiency could potentially affect all residents of the facility for risk of fire and smoke.</td>
<td>(K 226)</td>
</tr>
<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
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<tr>
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Surveyor: 40506
Based on observation and interview, the provider failed to maintain the two hour fire resistive rating of horizontal exits. The top latching hardware on one door leaf of the cross-corridor doors adjacent to rooms 161 and 162 was not functioning properly. Findings include:

The statements on this plan of correction are not admittance to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.

1) The top latching hardware on the door leaf of the cross-corridor door adjacent to rooms 161 and 162 was adjusted on 6/25/19 by the maintenance director so door did latch.
2) Maintenance Director will audit the door latch of the cross-corridor door adjacent to rooms 161 and 162 5x/week for 8 weeks to ensure the latch is functioning properly.
3) QAPI meets monthly; audits will be brought to meeting for review by the QAPI team. At this time a decision will be made to either continue or be resolved.

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<th>7/18/19</th>
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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. For deficiencies related to fire safety, the findings stated above are discloseable 90 days following the date of survey whether or not a plan of correction is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
<table>
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<tr>
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<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td>S 000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surveyor: 35237 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/24/19 through 6/25/19. Prairie Heights Healthcare was found in compliance.</td>
<td></td>
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