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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW ABERDEEN, SD 57401

(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	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/6/23 through 2/8/23. Prairie Heights Healthcare was found in compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darcy Albrecht
TITLE: Administrator
(X6) DATE: 02/16/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVENUE NW ABERDEEN, SD 57401

(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
E 000	Initial Comments 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 2/6/23 through 2/8/23. Prairie Heights Healthcare was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darcy Albrecht
TITLE: Administrator
(X6) DATE: 02/16/2023

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	**400 8TH AVENUE NW ABERDEEN, SD 57401**

(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	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/7/23. Prairie Heights Healthcare Building 01 was found not in compliance with 42 CFR 483.90 (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 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Aberdeen Plan of Correction for Annual Life Safety Code Survey of 2/7/23. 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 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.	
K 226 SS=C	Horizontal Exits CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the two-hour fire resistive rating of one randomly observed horizontal exit. The bottom latching hardware on both leaves of the cross-corridor doors adjacent to rooms 161 and 162 were not functioning properly. Findings include: 1. Observation on 2/7/23 at 12:05 p.m. revealed the bottom latching hardware installed on both	K 226	1) The bottom latching hardware leaves of the ninety-minute fire-rated cross-corridors doors adjacent to rooms 161 and 162 were removed and a thermal pin was installed at the bottom of the door on 2/8/23 by the maintenance so door will latch. 2) Maintenance Director will audit the upper latches 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.	2/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darcy Albrecht | TITLE: Administrator | (X6) DATE: 02/16/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	**400 8TH AVENUE NW** **ABERDEEN, SD 57401**

(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 226	Continued From page 1 leaves of the of ninety-minute fire-rated cross-corridor doors adjacent to rooms 161 and 162 did not latch. Interview with the director of maintenance at the time of the observation confirmed that hardware did not latch. The deficiency had the potential to affect all residents of the facility.	K 226		
K 321 SS=C	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321	1) The following doors were adjusted by the maintenance director so they latched on 2/8/23: a) the door from the oxygen storage room to the corridor b) the door from the laundry room to the corridor c) the door from the boiler/maintenance room to the corridor 2) The maintenance director will audit the 3 identified doors 5x/week for 8 weeks to ensure the doors are latching 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 continue or to resolve.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435004	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	**400 8TH AVENUE NW ABERDEEN, SD 57401**

(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 321	Continued From page 2 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain three separate hazardous areas (oxygen storage room, laundry room and boiler/maintenance room) as required. Findings include: 1. Observation and testing on 2/7/23 at 1:15 p.m. revealed the door from the oxygen storage room to the corridor was equipped with an automatic closer but would not latch into the frame as required. 2. Observation and testing on 2/7/23 at 1:48 p.m. revealed the door from the laundry room to the corridor was equipped with an automatic closer and a magnetic hold-open device tied to the buildings automatic fire alarm system. That door had coats hung on the outside with adhesive hooks. Those coats prohibited the door from closing and latching into the frame under the power of the automatic closer as required. 3. Observation and testing on 2/7/23 at 3:31 p.m. revealed the door from the boiler/maintenance room to the corridor was equipped with an automatic closer but would not latch into the frame as required. Interview with the director of maintenance at the times of the observations confirmed those findings. The deficiencies affected one of numerous requirements for hazardous storage rooms.	K 321		

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	435004	A. BUILDING **02 - BUILDING 02** B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	**400 8TH AVENUE NW ABERDEEN, SD 57401**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/7/23. Prairie Heights Healthcare Building 02 was found not in compliance with 42 CFR 483.90 (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 deficiency identified at K226 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Aberdeen Plan of Correction for Annual Life Safety Code Survey of 2/7/23. 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 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.	
K 226 SS=C	Horizontal Exits CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the two-hour fire resistive rating of one randomly observed horizontal exit. The bottom latching hardware on both leaves of the cross-corridor doors adjacent to rooms 161 and 162 were not functioning properly. Findings include: 1. Observation on 2/7/23 at 12:05 p.m. revealed the bottom latching hardware installed on both	K 226	1) The bottom latching hardware leaves of the ninety-minute fire-rated cross-corridors doors adjacent to rooms 161 and 162 were removed and a thermal pin was installed at the bottom of the door on 2/8/23 by the maintenance director so the door will latch. 2) Maintenance Director will audit the upper latches 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.	2/26/23

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

Darcy Albrecht | Administrator | 02/16/2023

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

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	435004	A. BUILDING **02 - BUILDING 02** B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	**400 8TH AVENUE NW** **ABERDEEN, SD 57401**

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K 226	Continued From page 1 leaves of the of ninety-minute fire-rated cross-corridor doors adjacent to rooms 161 and 162 did not latch. Interview with the director of maintenance at the time of the observation confirmed that hardware did not latch. The deficiency had the potential to affect all residents of the facility.	K 226		

South Dakota Department of Health

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	10588	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HEIGHTS HEALTHCARE	400 8TH AVE NW ABERDEEN, SD 57401

(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 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/6/23 through 2/8/23. Prairie Heights Healthcare was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darcy Albrecht — TITLE: Administrator — (X6) DATE: 02/16/2023

STATE FORM 6899 SEVG11 — If continuation sheet 1 of 1