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

PRINTED: 07/10/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435118	B. WING_			06/	14/2023
	ROVIDER OR SUPPLIER	ITER		40	REET ADDRESS, CITY, STATE, ZIP CODE ON SOUTH FIRST AVENUE OONSOCKET, SD 57385		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 812 SS=E	with 42 CFR Part 483 for Long Term Care fa 6/12/23 through 6/14/Center was found not following requirement Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using progradens, subject to consider safe growing and food (iii) This provision doe from consuming food safe growing and food (iii) This provision doe from consuming food safe growing and food (iii) This provision doe from consuming food safe growing and food (iii) This provision doe from consuming food safe growing and food safe growing and policy review, and policy reviews to for one flattop growing and for three ceiling safe policy for the form of three ceiling safe policy for three ceiling safe policy for the form of three policy for the form of three ceiling safe policy for the form of three ceiling safe policy for the form of three ceiling safe policy for the form of three policy for the form of thre	th survey for compliance s, Subpart B, requirements acilities was conducted from 123. Prairie View Healthcare in compliance with the 125. France Frepare/Serve-Sanitary 127. 128. Prepare/Serve-Sanitary 129. 139. The food from sources 149. Frequirements 159. Frequirements 169. Fre		312	affected. All areas identified were cleaned by 7/10/23. All expired and spoiled foods have been disposed of the ED or designee will educate etary staff on proper cleaning and station as well as disposing of spoiled of pired foods by 7/10/23. All staff not tendance will be educated prior to next working shift. 3. The ED or designee will conweekly audits times four weeks monthly times two months of the kits to check for spoiled/expired foods a proper cleaning of equipment. The designee will bring the results of the audits to the monthly QAPI meeting further review and recommendation continue or discontinue the audits.	all di- anita- or ex- in at- their duct and chen nd for ED or se for to	7/10/23
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	,	(X6) DATE

Kayla Evans

Executive Director

7/16/2023

Any deficiency statement engine with an asterisk redencted adequate which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (Sections.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or ast a pion of correction is provided 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.

JUL 19 2023

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

vent ID; XU2U11

Facility ID: 0108

If continuation sheet Page 1 of 6

		ND HUMAN SERVICES MEDICAID SERVICES				-	RM APPROVEI NO. 0938-039
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		435118	B. WING			(06/14/2023
NAME OF P	ROVIDER OR SUPPLIER	Access to the second se		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DD AIDIE V	ACIAL DEAL THOADE CE	MTED			SOUTH FIRST AVENUE		
PRAIRIE	E VIEW HEALTHCARE CENTER WOONSOCKET, SD 57385						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 812	dust. *Food items such as cider vinegar, and re discarded after the it *One of one hand so Findings include: 1. Observation on 6/p.m. in the kitchen re *The grease trap hol grill to the drawer was black greaseThe drawer was diff amount of grease. *The ceiling vent fan area and the cooking dust on the vent graf spreading out on the *In the walk-in coole-A gallon jug of dill re black slimy substance rimThere was a label of the cooking on themThere was a label of the cooking of the co	dill relish, tomatoes, apple d wine vinegar were em was spoiled or expired. Pap dispenser was functional. 12/23 from 3:37 p.m. to 3:58 evealed: Inwer under the flattop grill had hodles, and burnt grease in it. The entry that connected the flattop as caked with a thick layer of ficult to open due to the flattop are relief from the vent. There was: In the elish that had an unknown the growing near the opening which read "3-31-23 opened." atoes. Several tomatoes had any and white slimy substances which read "Tom 5-3." Toom, there was: In go of apple cider vinegar with	F	812			
:	11/18/20.	s "Best if used by" date was ug of red wine vinegar with a					

--There was no year to indicate what year the

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

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		435118	B. WING_			06	/14/2023
	ROVIDER OR SUPPLIER	NTER		STREET 401 SO WOOM			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	Continued From page product was openedThe manufacturer's 7/18/21There were two addi of red wine vinegar w by" date of 7/18/21. *There was a handwa and juice machine. The intervity of the dispenser had an 7/17." Observation on 6/13/1 the kitchen equipmer condition as above a products were still the Observation on 6/14/23 nutrition services (FA above observations in *She was not aware as it was. *She was aware of the agreed it needed to be *Their process for disfollows: -The night cook was cooler and discard fo expiration dateShe was not aware substance growing of	"Best if used by" date was itional unopened gallon jugs with the same "Best if used ashing sink near the coffee he hand soap dispenser was aming hand soap that was in expiration date of "EXP" 23 at 11:23 a.m. revealed he was still in the same and the spoiled/expired ere. 23 at 1:00 p.m. revealed the at 1:03 p.m. with food and the spoiled Eabout the	F	312	DEFICIENCY)		
	often in their recipes.						

		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 07/10/2023 A APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435118	B. WING			06/	14/2023
	ROVIDER OR SUPPLIER	ITER		40	TREET ADDRESS, CITY, STATE, ZIP CODE 11 SOUTH FIRST AVENUE 10 ONSOCKET, SD 57385		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	*She was not aware on the dry storage roof yearsShe indicated they do or apple cider vinegath Review of the provide Schedule" template in were included: *"Range - Catch Panter Were included: *"Handsink/Soap/Papter Were blank spadditions to the task of the provide Schedule" for 6/1/23 *The "Range - Catch marked as completed 6/4/23, 6/10/23, 6/11. *The "Handsink/Soap marked as completed and 6/12/23. Review of the provide Schedule" template in were included: *"Refrigerator - Clear ""Store Room - Clear ""Fans" *There were blank spadditions to the task	atoes over one month ago. of the several jugs of vinegar in that had been there for iid not use red wine vinegar in their recipes. Ber's 2018 "Daily Cleaning evealed the following items items access to provide hand-written list. Ber's "Daily Cleaning through 6/13/23 revealed: Pan" and "Grill" were if on 6/1/23, 6/2/23, 6/3/23, 6/23, and 6/12/23. Depar Towels" were if on 6/4/23, 6/10/23, 6/11/23, 6/10/23, 6/11/23, 6/10/23, 6/10/23, 6/10/23, 6/10/23, 6/11/23, 6/10/23, 6/10/23, 6/11/23, 6/10/23, 6/10/23, 6/11/23, 6/10/23, 6/10/23, 6/10/23, 6/11/23, 6/10/23	F	812			

"Week 5."

Schedule" for May 2023 revealed:

*The "Refrigerator - Clean/Organize" and "Fans" items were marked as being completed for

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

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	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLETED		
		435118	B. WING		06/14/2023		
	ROVIDER OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 812	Continued From page *The "Store Room - Conot marked as being." Review of the provide Schedule" template reverse included: *"Ceiling" *"Ceiling Lights and Continues - Clean" *There were blank spadditions to the task of the provide Schedule" for 2023 refered task item on the completed for "Month to the task item on the completed for "Month to the task item on the completed for "Month to the conflict of the provide schedule" for 2023 refered task item on the completed for "Month to the completed for "Ice Machine" -"Lowerator/Plate Wall-"Fire Extinguishers - "Drains - Clean" -"FANS Manager Office Review of the provide policy revealed:	Clean/Organize" item was completed that month. er's 2018 "Monthly Cleaning evealed the following items Covers - Clean" acces to provide hand-written ist. er's "Monthly Cleaning evealed: e list was initialed as being 1" and "Month 5." were initialed for "Month 2" lice Machine" and "FANS an." ollowing items had initialed rmers (Heavy Clean)" Wipe/Clean"	F 81				
	maintained in a clean environment." *"Procedure:" -"1. Food storage are times." -"5. Foods are dated delivery to the Center with used by dates of						

		ID HUMAN SERVICES MEDICAID SERVICES				ORM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	1, /	ATE SURVEY OMPLETED
		435118	B. WING_			06/14/2023
NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385	;ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 812	require labeling with a delivery." -"6. Food products ar unless the manufactudifferent." -"10. Opened items hon them May indic prepared if required be -"11. The manufactur available, is the use be Review of the provider revealed: *"Policy Statement: Tomaintained in a clear bear to the state of the provider revealed: ""1. Kitchens, kitcher kept clean, free from protected from roden insects." -"2. Utensils, counter are kept clean, maintained in a clear bear to the state of the provider of the state o	the moth and year of the used within one year there's expiration date is the date opened or date to your survey agency." ther's expiration date, when to y date for unopened items." there's 2019 "Sanitation" policy the food service area is the and sanitary manner." the areas, and dining areas are litter and rubbish, and tts, roaches, flies and other the sained in good repair, and are trosions, open seams, areas." the used within one year ther's expiration date in good repair, and are trosions, open seams, areas." the used within one year there's expiration date is the sained within one year there's expiration date is the used within one year there's expiration date is there's expiration date in good repair, and are trosions, open seams, areas."	F8	12		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_		0/6: 5:5	OUD CV
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(-/		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435118	B. WING			06/14/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDAIDIE)	/IEW HEALTHCARE CEN	UTED			01 SOUTH FIRST AVENUE		
PRAIRIE	/IEW REALINCARE CEN	VIEN		W	VOONSOCKET, SD 57385		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	Y	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
PREFIX TAG	DECLIFICATION OF LCC IDENTIFYING INFORMATIONS		TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					BEI ICIENOT/		
E 000	Initial Comments		Ε¢	000			
	A recertification cum	ey for compliance with 42					
		art B, Subsection 483.73,					
	Emergency Prepared	Iness, requirements for Long					
		vas conducted from 6/12/23					
	was found in complia	rie View Healthcare Center					
	Wao touria in compile						
1							
					7)71.5		(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	and	
Kayla	Evans				Executive Director		6/2023
Any deficiency	statement ending with an a	an texte extients (See instructions) Exce	ot for nursi	ina ho	excused from correcting providing it is determined omes, the findings stated above are disclosable 90	uays	
following the d	late of survey whether or no	a plan of derrection is provided. For nursin	a homes, t	he ab	pove findings and plans of correction are disclosable	e 14	
days following	the date these documents	are made available to the facility. If deficienc	cies are cite	ed, ar	n approved plan of correction is requisite to continu	su	

SD DOH-OLC

JUL 0 6 2023

Event ID: XU2U11

program participation.

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

Facility ID: 0108

If continuation sheet Page 1 of 1

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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D1 - PRAIRIE VIEW CARE CENTER		3) DATE SURVEY COMPLETED		
		435118	B. WING			06/	13/2023		
	ROVIDER OR SUPPLIER	ITER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE		
K 000	Life Safety Code (LS occupancy) was cond View Healthcare Cen	ey for compliance with the C) (2012 existing health care ducted on 6/13/23. Prairie ter was found in compliance a) requirements for Long	K	000					
							(VO) DATE		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE Tagget for Director	-7	(X6) DATE		

Kayla Evans

Executive Director

7/6/2023

Any deficiency statement ending with an asterist (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient by decition 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.

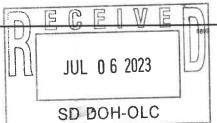
	-	
	·	

South Dakota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		10714	B. WNG		06	/14/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
PRAIRIE \	/IEW HEALTHCARE CEN	ITER	OCKET, SD 57385				
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S 000	44:73, Nursing Facilit	compliance with the of South Dakota, Article ies, was conducted from 23. Prairie View Healthcare	S 000				
S 000	44:74, Nurse Aide, re training programs, wa	compliance with the of South Dakota, Article quirements for nurse aide as conducted from 6/12/23 rie View Healthcare Center	S 000				

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

Kayla Evans



TITLE

Executive Director

(X6) DATE

7/6/2023

VTJT11

If continuation sheet 1 of 1