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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Heights Healthcare	400 8th Avenue NW Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49238 Based on the South Dakota Department of Health (SD DOH) complaint report, interview, record review, the provider failed to ensure services provided for four of four sampled residents (1,2,3,4,) did not meet professional standards by: *Director of nursing (DON) (B) who did not follow the rights of medication administration nor the facility policy for insulin administration when administering insulin to resident 1. *DON B who did not document a wound assessment at the time of completion or identify it as a late entry when it was documented in resident 4's medical record. *Two certified medication aides (CMA) (C and D) who did not remain within their unlicensed but certified skill set. Findings include: Surveyor 50915 1. 4. Interview on 10/23/24 at 3:30 p.m. with director of nursing (DON) B revealed: *She confirmed she made the medication error regarding resident 1's insulin on 7/6/24 at 9:00 p.m. *She confirmed resident 1 should have been administered 62 units of Lantus (long-acting insulin) insulin, he instead received 55 units of Humalog (fast-acting) insulin. 2. Review of the provider's medication error report dated 7/6/24 at 9:00 p.m. revealed: *The report confirmed that resident 1 received 55 units of Humalog insulin instead of the ordered 62 units of Lantus insulin. *The report indicated a contributing factor to the error was Both Lantus and Humalog pens were stored in the same baggie in the cart with one label. *The report indicated when DON B got a new Lantus insulin pen to prepare to administer the remaining 7 units of resident 1's Lantus insulin, she realized that the insulin pens were two different colors, and identified the medication error had occurred. (continued on next page)

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.

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

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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Heights Healthcare	400 8th Avenue NW Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The report indicated the on-call provider was called, the Lantus insulin dose was held, and the resident was given a snack. *The report indicated that the resident was not taken to the hospital. 3. Review of resident 1's electronic medical record (EMR) revealed: *Progress note on 7/6/24 at 9:00 p.m., Dr. [name], on call, updated on insulin use and that current blood sugar is 215 with the following orders: Check blood sugars every hour for the next 4 hours, 10 p.m., 11 p.m., 12 a.m., and 1 a.m. Do not give Lantus tonight. Call on call provider again in the am with the a.m. blood sugar results to see if added Lantus should be given. Pt [patient] aware, Daughter [name] updated on orders. *On 7/6/24 at 10 p.m., resident 1's blood glucose was 143 milligrams per deciliter (mg/dl). *On 7/6/24 at 11 p.m., resident 1's blood glucose was 115 mg/dl. *On 7/7/24 at 12 a.m., resident 1's blood glucose was 123 mg/dl. *On 7/7/24 at 1 a.m., resident 1's blood glucose was 118 mg/dl. *Resident 1 was given snack as order by on-call physician. -He did not show any signs of hypoglycemia. Review of the SD DOH complaint report dated 10/4/24 revealed: *The complainant wished to remain anonymous. -Director of nursing (DON) B was at a conference but had charted that she completed a wound assessment on resident 4 when she returned from the hospital 9/24/24. -DON B was not in the building at the time that resident returned from the hospital and could not have performed that assessment she documented on. -Certified medication aides completed duties outside their scope of practice. Surveyor 49238 4. Interview on 10/23/24 at 11:19 a.m. with director of nursing (DON) B revealed: *She had gone to a conference but had come back on the 10/24/24 to see resident 2 who had returned from the hospital. -She stated she did not feel she could depend on the nurse who had been working and wanted to see the resident herself. *She had to complete a wound assessment for resident 2 who came back from the hospital with a deep tissue injury on her heel. (continued on next page)

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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Heights Healthcare	400 8th Avenue NW Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She agreed she completed the documentation for that wound assessment the next day remotely. *She agreed she should have charted the wound assessment as a late entry, but she did not. *She stated she would work Monday through Friday from 8:00 a.m. to 4:30 p.m. and sometimes stay until 5:30 p.m. and would chart remotely from home. 5. Review of medication administration records (MARs) revealed: *Certified medication aide (CMA) D had documented antipsychotic medication side effects on 8/8/24 and 8/20/24 for resident 3. *She had documented a pain assessment for resident 4 on 9/6/24. 6. Interview on 10/24/24 at 9:48 a.m. with CMA C revealed: *She stated she had not been trained on how to assess for psychotropic [brain altering medication that treat psychotic conditions such as delusions and hallucinations] medication side effects at this facility but had documented behavior information for the residents she was familiar with. -She charted yes or no answers for residents behaviors. *She stated she assessed residents for their pain level by resident's verbal answers or by the resident's facial expression and then documented their pain level. -She would report pain levels to the nurse that were five out of ten or higher. 7. Interview on 10/24/24 at 11:40 a.m. with DON B regarding CMAs completing pain and psychotropic medication assessments revealed: *DON B admitted that two CMAs (C and D) had documented pain and psychotropic medication assessments, and she had just heard about that from CMA C after her interview with the surveyors. -She said CMA C asked her today if she should have been charting those things and DON B told no. *DON B stated she was not aware they had been doing that and it was not in their scope of practice, but she had instructed them to stop. 8. Review of the providers's September 2014 Insulin administration policy revealed: *Preparation section, number three, The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. 9. Review of the provider's medication aide job description dated Qtr 2,2020 revealed: *Administering Medications-Specific to Unlicensed Medication Aides. (continued on next page)

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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Heights Healthcare	400 8th Avenue NW Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-20. Medications administration tasks that may not be delegated to unlicensed assistive personnel (Unlicensed Medication Aides) are the following; -6. Exercising of nursing judgement, assessments which would require nursing intervention.

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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Heights Healthcare	400 8th Avenue NW Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50915 Based on South Dakota Department of Health (SD DOH) complaint online report, interviews, record review, and policy review, the provider failed to keep one of one resident (1) free from a significant medication error when administered an incorrect dose of insulon by director of nursing (B). Findings include: 1. Review of SD DOH 10/4/24 complaint report revealed: *DON B had a major medication error where she gave the incorrect insulin (large dose) to a resident but it was never reported or counted as a medication error. *The complainant identified the resident in this incident as resident 1. 2. Interview on 10/22/24 at 2:40 p.m. with resident 1 revealed: *He had a Brief Interview for Mental Status (BIMS) score 8, which indicated he had moderate cognitive impairment. *He reported that the staff did a good job providing care for him. *He confirmed he was diabetic and required insulin injections. *He was unable to recall ever having any problems getting his insulin. 3. Interview on 10/23/24 at 9:55 a.m. with certified medication aide (CMA) C revealed CMAs did not obtain blood glucose (level of sugar in blood) readings or administer insulin. 4. Interview on 10/23/24 at 3:30 p.m. with director of nursing (DON) B revealed: *She confirmed she made the medication error regardingn resident 1's insulin on 7/6/24 at 9:00 p.m. *She confirmed resident 1 should have been administered 62 units of Lantus (long-acting insulin) insulin, he instead received 55 units of Humalog (fast-acting) insulin. 5. Review of the provider's medication error report dated 7/6/24 at 9:00 p.m. revealed: *The report confirmed that resident 1 received 55 units of Humalog insulin instead of the ordered 62 units of Lantus insulin. *The report indicated a contributing factor to the error was Both Lantus and Humalog pens were stored in the same baggie in the cart with one label. *The report indicated when DON B got a new Lantus insulin pen to prepare to administer the remaining 7 units of resident 1's Lantus insulin, she realized that the insulin pens were two different colors, and identified the medication error had occurred. (continued on next page)

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	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Heights Healthcare	400 8th Avenue NW Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The report indicated the on-call provider was called, the Lantus insulin dose was held, and the resident was given a snack. *The report indicated that the resident was not taken to the hospital. 6. Review of resident 1's electronic medical record (EMR) revealed: *Progress note on 7/6/24 at 9:00 p.m., Dr. [name], on call, updated on insulin use and that current blood sugar is 215 with the following orders: Check blood sugars every hour for the next 4 hours, 10 pm, 11 pm, 12 am, and 1 am. Do not give Lantus tonight. Call on call provider again in the am with the 7am blood sugar results to see if added Lantus should be given. Pt [patient] aware, Daughter [name] updated on orders. *On 7/6/24 at 10 p.m., resident 1's blood glucose was 143 milligrams per deciliter (mg/dl). *On 7/6/24 at 11 p.m., resident 1's blood glucose was 115 mg/dl. *On 7/7/24 at 12 a.m., resident 1's blood glucose was 123 mg/dl. *On 7/7/24 at 1 a.m., resident 1's blood glucose was 118 mg/dl. *Resident 1 was given snack as order by on-call physician. -He did not show any signs of hypoglycemia. 7. Review of the providers's September 2014 Insulin administration policy revealed: *Preparation section, number three, The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.