| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435118 | A. Building<br>B. Wing | 11/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Prairie View Healthcare Center | 401 South First Avenue<br>Woonsocket, SD 57385 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 |
|---|---|---|
| | | |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, and record review, the provider failed to ensure one of one certified nursing assistant (CNA) E transported a resident with the use of the wheelchair pedals according to American Healthcare guidelines implemented by the facility, for one of one resident (1) who developed pain to her right knee, and could not bear weight on her right leg, and was transferred to the hospital emergency department (ED) for further evaluation. Findings include:1. Review of the provider's 10/20/25 submitted FRI to the SD DOH regarding resident 1 revealed on 10/19/25 at approximately 6:30 p.m. CNA E did not follow guidelines for the use of wheelchairs implemented by the facility according to the American Healthcare Association for the resident. She developed pain to her right knee and could not bear weight on her right leg and as a result, she required an evaluation at the hospital's ED for radiographic images (X-ray). The facility did not have a policy that was specifically related to the use of wheelchairs and indicated they follow the American Healthcare guidelines for wheelchair use. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incidents. On 10/19/25 at approximately6:30 p.m. resident 1 was self-propelling herself in her w/c following the evening meal. She had foot pedals on the w/c, but the pedals were not in use at the time of the incident. Both foot pedals had been rotated to the sides of the w/c. CNA E had come from behind her w/c and provided assistance by pushing the w/c without using the foot pedals. While pushing resident 1 in the w/c CNA E had turned the corner of the hallway and her right foot had become lodged under the w/c and resulted in the wheelchair's right front wheel rolling over the resident's foot. Resident 1 had yelled Stop after the chair had rolled on top of her right foot and CNA E immediately stopped the w/c. CNA E had offered resident 1 an ice pack following the incident, but the resident had declined the offer. Neither CNA E nor the resident had reported the incident to the nurse. Resident 1 had no concerns following the incident until she had therapy the evening of 10/19/25. During the therapy session, resident 1 could not bear weight on her right leg because of the knee pain. The nurse was notified of the incident that occurred with resident 1 earlier in the evening, and the pain she was having in her right knee. The resident's primary care physician and power of attorney were notified of the incident. Orders were received by the physician to transfer the resident to the ER for further assessment and X-rays. Resident 1 received x-rays while she was the ED and the findings had shown Tri compartment degenerative change (deterioration of cartilage in all three major compartments of the knee joint, medial, lateral, and patellofemoral) with no fractures. Resident 1 was given a knee immobilizer for her right knee and it was to be worn as needed for comfort until the pain in her knee subsides. Resident 1 was able to bear weight on her right leg and transfer with minimal discomfort. She continued to receive physical, occupational, and skilled therapy that had begun when she was first admitted to the facility on [DATE]. On 10/21/25 resident 1 was measured for a manual custom fit w/c. The custom fit w/c would allow the resident to have easier movement and motion. She had been using a wheelchair that belonged to the facility since her admission on [DATE]. On 10/23/25 documentation was provided and revealed interim director of nursing (IDON) B provided one on one training with CNA E prior to her next working shift after the incident that occurred on 10/19/25. CNA E was educated on the process to report any change in condition of residents, wheelchair etiquette, and the use of foot pedals on wheelchairs. She was required and completed additional education on CareFeed (online education) on how staff make themselves aware of the resident, ask the resident for their permission to assist them prior to moving their wheelchair. Stop-Listen-then action to prevent injuries and respect resident rights and dignity. 2. Review of resident 1's electronic medical record (EMR) revealed her Brief Mental Status (BIMS) score was 15, which indicated she was cognitively intact. She was admitted to Prairie View Healthcare Center with a diagnoses of chronic kidney disease (CKD), peripheral vascular disease (narrowed or blocked arteries), major depressive disorder, morbid (severe) obesity, hypothyroidism, type 2 diabetes, and gastro esophageal reflux disease (chronic condition where the stomach contents flow back into the esophagus). Review of resident 1's most updated care plan revealed she used a four-wheel walker and a wheelchair for transfers. Resident 1 had difficulties related to activities of daily living related to CKD, frequent falls prior to admit, morbid obesity evidence-based deconditioning and weakness from recent hospitalization prior to admit. 3. Interview and observation on 11/5/25 at 10:48 a.m. with registered nurse, social services director (RN SSD) C revealed wheelchair audits were initiated since the incident that occurred on 10/19/25 |