STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435118	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie View Healthcare Center	401 South First Avenue 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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Minimal harm or potential for actual harm 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) review, record review, interview, observation, and policy review, the provider failed to ensure two of two registered nurses (social services director D and interim director of nursing B) initiated cardiopulmonary resuscitation (CPR) (a life-sustaining measure) for one of one resident (1) who was found unresponsive. The resident was designated as a Full Code/Full treatment (receive all life-saving interventions, such as CPR, defibrillation, intubation, and mechanical ventilation, in the event of a medical emergency). She was found in her bed at approximately 8:24 a.m. and appeared to be pale (light shade of color) and ashen (gray) in color, cool to the touch, with no visible movement, and without a pulse. The resident had passed away. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incident.Findings Include: 1. Review of the provider's [DATE] submitted FRI to the SD DOH revealed on [DATE] at approximately 8:24 a.m., certified nursing assistant (CNA) H, social services director (SSD) D, and interim director of nursing (IDON) B did not follow facility's CPR policy and did not initiate life-sustaining measures for resident 1 when she was found unresponsive. The resident was deceased as of [DATE] at 8:30 a.m.On [DATE] at approximately 8:24 a.m., CNA H called for assistance to resident 1's room. SSD D responded immediately and upon her arrival she found the resident in her bed, and appeared pale, ashen, cool to the touch, and had no visible movement. The resident had no blood pressure, pulse, or respirations. A significant amount of blood was observed on the resident's bed linens. IDON B and licensed practical nurse (LPN) E reported to resident 1's room after SSD D.At 8:26 a.m., SSD D attempted to contact certified nurse practitioner (CNP) G but was unable to speak directly with her.At 8:28 a.m., SSD D called medical director (MD) F to inform him of resident 1's passing.At 8:30 a.m. CNP G arrived at the facility and assessed resident 1 and confirmed the resident was deceased . CNP G indicated that the resident's cause of death was likely uterine hemorrhage (excessive or abnormal bleeding from the uterus) followed by cardiac arrest (heart suddenly and unexpectedly stops beating due to an electrical malfunction). SSD D and CNP G notified resident 1's family that she had passed away.The FRI had indicated that resident 1 was diagnosed with cervical cancer, suspected to be stage IV (more advanced stage) with possible liver metastasis (metastatic liver cancer), and presented with post-menopausal bleeding that was experienced for several months prior to admission on [DATE].Resident 1 was a full code/full treatment status, but no life-sustaining measures had been initiated from the immediate staff upon their arrival and finding the resident unresponsive.SSD D and IDON B were suspended pending the full investigation.Immediate education was provided for all staff on CPR procedures and proper use of the code status binder (the binder that had a list of all residents who resided in the facility, that indicated their code status) that was readily available for all staff to view.The FRI indicated that resident 1 was assessed at 4:00 a.m. by the night nurse. The FRI did not include any additional information about why the night nurse assessed the resident, or the results of that assessment.Interview on [DATE] at 3:05 p.m. with administrator A revealed resident 1 was not assessed at 4:00 a.m. as the initial FRI had indicated. The night nurse had observed resident 1 in her bed at that time while the nurse administered medications to another resident whose room was close to resident 1's room.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 the facility 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 [DATE] care plan revealed she had an advanced directive. The goal was, I will have my desires and wishes followed according to my signed directive. One of the associated interventions read, Staff will understand and follow my healthcare directives.Her CPR/DNR directive dated [DATE] indicated that she was to receive CPR/Full Resuscitative measures in the event of a cardiac arrest (heart attack).A gynecologic oncology report dated [DATE] revealed resident 1 was diagnosed with cervical cancer, possible stage IV (liver metastasis).3. Interview on [DATE] at 11:10 a.m. with CNA I revealed she had not received CPR training. She had worked at the facility as a cook prior to being a CNA and she knew where the code status binder was to tell her if a resident was designated as a DNR or a full code status. She stated she was CPR certified in the past, but her certificate had expired She planned to take the next CPR class that was offered for staff to become CPR