| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 43A113 | A. BUILDING _____ B. WING _____ | 07/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AVERA OAHE MANOR | 700 E GARFIELD GETTYSBURG, SD 57442 |

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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 40788<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/13/21 through 7/15/21. Avera Oahe Manor was found not in compliance with the following requirements:F679, F684, F811, F842, and F849. | F 000 | | |
| F 679 SS=E | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 40788<br>Based on observation, interview, record review, job description review, and policy review, the provider failed to fully implement an activity program based on resident assessment and preference for two of two sampled residents (3 and 21) in the memory care unit (MCU). Findings include:<br><br>1. Observation on 7/13/21 between 2:40 p.m. and 5:05 p.m. of residents 3 and 21 revealed:<br>*The dining area and television lounge were a combined space.<br>*Resident 3 sat in a recliner in the television | F 679 | On 7/16/21, residents 3 and 21 were reassessed for activities preferences and care plans were updated to accurately reflect the changes.<br>On 8/4/21 education and training for therapeutic programming was provided by the Director of Resident Care, to activities coordinator P and activities assistant O on assessment, documentation, care planning, one to one's and activities calendars.<br><br>Education will be provided by the Director of Resident Care, to activities coordinator P, activities assistant O, medication aide F, LPN M and G, CNA Q, and all other direct care staff regarding MCU activities calendar being followed, appropriate one to one activites, and having residents ready for scheduled activites on and off the MCU by 9/3/21.<br><br>Direct care staff will be provided by the DRC, with index cards containing residents' preferences, the use of a communication tool for activities/events, and a list of available items and ideas for activities for the MCU residents by 9/3/21.<br><br>The DRC or designee will conduct audits two times weekly for the first three months, then monthly thereafter, on activites compliance in the MCU. Findings will be reported by the DRC or designee to the QAPI committee monthly or until the QAPI committee determines compliance has been reached. | 9/3/21 |

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

Kristie Livermont, Administrator | 8/4/21

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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| F 679 | Continued From page 1 | F 679 | | |

lounge area with the television on.
-Her eyes remained closed until 3:22 p.m. when she awoke.
*Resident 21 had been in a recliner in that same television lounge.
-His recliner was positioned so that he was unable to see the television screen.
*He remained in that recliner with his eyes closed.
*Both residents were assisted out of their recliners and into their wheelchairs for the evening meal about 5:00 p.m.

Interview on 7/13/21 at 5:10 p.m. with medication aide F regarding the MCU activity schedule for that date revealed:
*One of eight residents had attended church outside of the MCU at 10:00 a.m.
*No one had attended the table time activity scheduled at 11:00 a.m.
*Water painting scheduled for 2:00 p.m. had not occurred.
*Ice cream cup activity scheduled for 2:30 p.m. had not occurred.
*Activities assistant O tried to take a few MCU residents off the unit for daily activities otherwise MCU staff tried to "entertain them".

Observation on 7/14/21 between 9:15 a.m. and 10:45 a.m. revealed:
*Resident 3 was in a recliner in the television lounge area with the television on.
-Her eyes were closed.
*Resident 21 sat in his wheelchair at the dining table, finished breakfast then was moved to a recliner in the television lounge area.

Interview on 7/14/21 at 5:40 p.m. with licensed practical nurse M regarding the MCU activity schedule for that date revealed:

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| F 679 | Continued From page 2<br>*Activities assistant O had not worked that day.<br>*The polish nails activity scheduled for 10:00 a.m., table time activity at 11:00 a.m., and ball toss scheduled for 2:30 p.m. had not occurred.<br>*Activities coordinator P had delivered popcorn for the 2:30 p.m. popcorn/pop activity.<br><br>Observation on 7/15/21 at 9:37 a.m. of residents 3 and 21 revealed:<br>*Resident 3 was at the dining table with a ball in her lap and manipulative items in front of her.<br>-She had not interacted with any of those items.<br>*Certified nurse aide (CNA) Q sat next to resident 3 and worked on a laptop computer.<br>*Resident 21 sat in a recliner in a corner of the television lounge unable to see the television that was on.<br><br>Interview on 7/15/21 at 9:45 a.m. with CNA Q and LPN G regarding residents 3 and 21 revealed:<br>*It was typical for residents 3 and 21 to sit in recliners after breakfast until lunch then return to those recliners for the afternoon until the evening meal.<br>*Resident 21's wife visited weekly or every other week.<br>-Staff assisted him to call her when he requested.<br>*Neither resident had participated in the Music and Memory program but other residents had.<br><br>Observation on 7/15/21 at 12:50 p.m. in the MCU dining area revealed: a counter top with multiple plastic containers filled with activity items such as a gadget board, colored pencils, crayons, paper, flash cards, puzzles, assembly type items similar to Legos, and a plastic ball.<br><br>Review of resident 3's activity care plan last revised on 3/25/21 revealed the following activity | F 679 | | |

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| F 679 | Continued From page 3<br>preferences:<br>*Spending most of her time in the dining room/activity area.<br>*CD player in her room.<br>*Has a permission slip to use Music and Memory as an activity.<br>*Nails polished and hair combed.<br>*Attend church services off unit two times per week.<br>*Beauty shop weekly.<br>*Will encourage more involvement by next evaluation.<br><br>Review of resident 21's care plan last revised on 6/14/21 revealed the following activity preferences:<br>*Looking at local newspapers, farm magazines, and daily news sheets.<br>*Visits and phone calls with his spouse.<br>*Church activities two times weekly off the MCU.<br>*Watching westerns.<br>*Manipulating a gadget board or other sorting activity.<br>*Wearing his baseball hat and attending daily coffee time.<br>*Any kind of action game.<br>*Encourage activities out of the MCU.<br><br>Review of the 7/1/21 through 7/15/21 Activity One-on-Ones documentation revealed:<br>*There was a list of twenty-one one on one activity ideas for residents that had not attended activities on a regular basis.<br>*Helping resident 3 with a meal had been documented as a one on one activity six times.<br>-Looking at pictures had been documented once.<br>*Resident 21 had not been identified as a resident meeting one on one activity criteria. | F 679 | | |

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| F 679 | Continued From page 4<br>Interview on 7/15/21 between 1:15 p.m. and 2:00 p.m. with activities coordinator P regarding the monthly MCU activity schedule revealed:<br>*The only regularly scheduled activities on the calendar that occurred off the MCU unit were inspiration time every Tuesday and Thursday and scripture time every Tuesday.<br>-It was the responsibility of nursing staff to have residents up and in their wheelchairs so activities staff could transport them to those church activities.<br>-She had not prepared a list of residents she had expected nursing staff to have ready to be taken to activities off the MCU.<br>*She confirmed that between 6/1/21 and 7/15/21 documentation showed residents 3 and 21 had each been offered the opportunity to attend church off the MCU two times.<br>*She confirmed documented one on one activities for resident 3 referred to above had not been acceptable.<br>*Activities assistant O led the weekday table time activity on the MCU.<br>-That occurred prior to lunch and might include activities such as ball rolling, reading or a craft.<br>*Nursing staff had been expected to carry out the table time activity if activity assistant O was absent as well as all other activities on that activity schedule unless otherwise indicated.<br>-Some nursing staff were better than others about ensuring those activities had occurred as scheduled.<br>-She helped as she was able to.<br>*She was not sure how to raise the expectations and accountability for implementation of the MCU activity calendar and not spoken to her immediate supervisor about that dilemma.<br><br>Review of the undated Activity Calendar/Schedule | F 679 | | |

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| F 679 | Continued From page 5<br>policy revealed:<br>*Activities:<br>-"Activities are individualized to increase participation according to hobbies, habits and life roles. If resident is able, they may participate in activities in both sections (memory care unit and general population unit) of the nursing home."<br>*Staffing:<br>-"Staff is equipped with the knowledge needed to care for people with dementia. All staff working in the Haven (memory care unit) attend yearly education."<br><br>Review of the undated Activity Coordinator job description revealed:<br>*Job Summary:<br>-Plan, develop and implement activities programs that assist in maintaining each resident's highest functioning level dealing with physical, social, spiritual and mental well-being aspects.<br>-Assess each resident for activity abilities and interest and develop an individual care plan as indicated from the assessment.<br>-Contact different departments for consultation to meet the resident's needs.<br>-Communicate concerns and/or progress to those departments. | F 679 | | |
| F 684<br>SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered | F 684 | | |

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| F 684 | Continued From page 6<br>care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 40053<br>Based on observation, interview, record review, and policy review, the provider failed to:<br>*Implement a repositioning schedule for one of one sampled resident (23) at risk for skin breakdown.<br>*Ensure one of one sampled resident's (8) injury of unknown origin was reported, assessed and investigated. Findings include:<br><br>1. Random observations on 7/13/21 from 8:15 a.m. through 6:45 p.m., on 7/14/21 from 7:45 a.m. through 6:00 p.m., and on 7/15/21 from 7:30 a.m. through 10:50 a.m. of resident 23 revealed:<br>*She had been in her room sitting upright or partially reclined in her Broda chair.<br>*She had not been repositioned from side to side while sitting in the her Broda chair or moved out of the chair to relieve pressure to her back, buttocks, back of her arms, or back of her thighs.<br><br>Record review revealed resident 23 was at moderate risk for skin breakdown.<br><br>Interview on 7/14/21 at 4:33 p.m. with registered nurse (RN) coordinator J regarding resident 23 revealed:<br>*While she worked night shift she observed resident 23 not being repositioned.<br>*She entered a scheduled repositioning time for two times at night.<br>-Midnight and 3:00 a.m.<br>*She had not entered any other scheduled repositioning times.<br><br>Interview on 7/14/21 at 5:18 p.m. with medication | F 684 | On 7/15/21 the two hour intervention for reposition resident 23 was added and implemented to avoid any potential harm caused to resident.<br>The two hour intervention for repositioning was also added to all residents who are unable to reposition themselves.<br>DON or designee will audit the completion of the two hour interventions being done for all residents unable to reposition themselves, weekly for the first four weeks and monthly thereafter. Findings will be reported by the DON or designee to the QAPI Committee monthly or until QAPI committee determines compliance has been reached.<br><br>On 7/21/21, education was given to all nursing staff that if a resident does not want to be respositioned, this must be documented in the medical record. Nursing staff unable to attend the mandatory meeting will be educated by 9/3/21.<br><br>Facility defined reminder implemented by completion date will include repositioning sheets in each eligible residents rooms. DON or designee will audit weekly for the first four weeks and monthly thereafter.<br><br>Visual observation of six residents weekly for two weeks then six residents every two weeks then as determined by the QAPI committee.<br><br>Findings will be reported by the DON or designee to the QAPI committee monthly or until QAPI committee determines compliance has been reached. | 9/3/21 |

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| F 684 | Continued From page 7<br>aide L regarding repositioning of resident 23 revealed:<br>*They repositioned her by reclining the Broda chair back into a semi laying position.<br>*She did not know of any other way of repositioning her.<br><br>Interview on 7/14/21 at 5:18 p.m. with RN D regarding repositioning of residents revealed all residents should be repositioned at least every two hours.<br><br>Interview on 7/15/21 at 9:08 a.m. with director of nursing (DON) B regarding resident 23 revealed:<br>*She agreed resident 23 was unable to reposition herself.<br>*Her expectation was that resident's unable to reposition themselves would have been repositioned at least every two hours.<br>*She stated RN coordinator J had noticed resident 23 was not being repositioned at night.<br>*On 6/27/21 RN coordinator J added a repositioning task in the electronic medical record.<br>*That repositioning task was only scheduled for two times in a 24 hour period.<br>-It had been scheduled for midnight and three a.m.<br>-There were no other scheduled repositioning times.<br>*DON B agreed leaning a resident back in their Broda chair into a reclining position was not considered repositioning.<br>*She agreed the repositioning task should be update for repositioning every two hours.<br><br>Review of the 9/2019 last reviewed "Pressure Ulcer Prevention Policy/Procedure" revealed:<br>*"VII. Related documents." | F 684 | | |

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| F 684 | Continued From page 8<br>*"iii. Repositioning."<br>-"Turn patient every two hours; use a facility-defined reminder."<br>*"Seated patient."<br>-"Limit the time to two hours for patients in seated position."<br>*"b. Moderate Risk: Braden Scale score 13 to 14."<br>-"ii. Repositioning."<br>-"Reposition patient every two hours according to facility-defined turning reminders. Evaluate for increased turning/small shifts (every one hour, every 30 minutes)."<br>Surveyor: 43844<br>2. Observation and interview on 7/13/21 at 3:02 p.m. with resident 8 revealed she had:<br>*A bruise measuring approximately two inches by one inch just above the inside of her elbow which had been green and purple in color.<br>*Not been responsive to attempts at conversation.<br><br>Review of resident 8's medical record and care plan revealed:<br>*Her brief interview of mental status indicated she had severe cognitive impairment.<br>*Her care plan reflected she should have had weekly skin assessments.<br>*Skin assessments completed on 7/6/21 and 7/13/21 had not identified she had a bruise.<br><br>Interview on 7/14/21 at 4:10 p.m. with director of nursing B regarding a bruise of resident 8 revealed she:<br>*Had not been aware of any bruising.<br>*Thought licensed practical nurse (LPN) G might know something as she had been in charge of skin conditions of residents. | F 684 | Reporting Injuries of Unknown Cause<br>On 7/21/21 education was provided to all nursing staff on injury of Unknown Origin and DOH reporting requirements.<br>On 7/22/21 education module on reporting injuries was created by DON and assigned out to all nursing staff to read through and sign off on by 9/3/21.<br>On 7/21/21 education was provided by DON to all nursing staff on skin assessments and CNAs requirement to report any skin concerns to the charge nurse.<br><br>The charge nurse will check with staff daily each shift if they had observed any new skin concerns on any residents.<br>Skin assessment policy is to be developed by DON and LPN G by 9/3/21.<br>DON added Reporting Injuries of Unknown Cause to annual education calendar each July. | |

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| F 684 | Continued From page 9<br>Interview and observation on 7/14/21 at 4:52 p.m. with LPN G regarding bruising of resident 8 revealed:<br>*Skin assessments were completed on a weekly basis.<br>*She had not been aware of a bruise.<br>*She had then assessed resident 8 and measured the bruise to be 2.1 centimeters (cm) x 4.7 cm on her left arm.<br>*The process for injury of unknown origin was to have been:<br>-A nurse would be notified upon finding by a certified nursing assistant (CNA).<br>-The nurse would have measured and completed a skin assessment.<br>-Any injury would have been reported to the DON for investigation.<br>*The bruise should have been reported to someone and investigated.<br>*Resident 8 was unable to say what had happened.<br>*She would notify the DON for an investigation to be completed.<br><br>Interview on 7/14/21 at 5:15 p.m. with CNA H regarding bruising of resident 8 revealed she:<br>*Had assisted her on 7/13/21 to the restroom and had not seen any bruising.<br>*Would have reported to a nurse the bruise if she had seen it.<br><br>Interview on 7/15/21 at 12:44 p.m. with medication aide F regarding the bruising of resident 8 revealed she:<br>*Had seen the bruise on 7/10/21.<br>*Had not reported it to anyone.<br>*Knew she should have reported the bruise to a nurse.<br>*Assumed someone else would have reported it. | F 684 | | |

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| F 684 | Continued From page 10<br><br>Interview on 7/15/21 at 12:44 p.m. with DON B regarding the bruise on resident 8 revealed:<br>*She agreed the bruise should have been reported to her when it was first noticed.<br>*Employees sometime assume someone else reported an injury.<br>-Knew they should report any injures to a nurse.<br>*Had provided education to staff regarding reporting injuries on 2/21/20 and 5/20/20.<br><br>Interview with 7/15/21 1:30 p.m. with DON B revealed:<br>*They did not have a skin assessment policy.<br>*They had been developing a skin care program.<br>*Skin assessments had been done the day a resident received a bath.<br><br>Review of providers' October 2017 Abuse, Neglect, Mistreatment and Misappropriation of Resident Property revealed:<br>*"g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met: i. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. ii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." | F 684 | | |
| F 811 SS=D | Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3)<br><br>§483.60(h) Paid feeding assistants-<br>§483.60(h)(1) State approved training course. A | F 811 | | |

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| F 811 | Continued From page 11<br>facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if-<br>(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and<br>(ii) The use of feeding assistants is consistent with State law.<br><br>§483.60(h)(2) Supervision.<br>(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).<br>(ii) In an emergency, a feeding assistant must call a supervisory nurse for help.<br><br>§483.60(h)(3) Resident selection criteria.<br>(i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.<br>(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.<br>(iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 40788<br>Based on observation, interview, and record review, the provider failed to ensure:<br>*The appropriateness for dining assistance had been documented in three of three observed residents' (3, 9, and 27) care plans who had received dining assistance.<br>*One of three observed dining assistants (M) had not fed one of three observed residents (9) who | F 811 | On 7/16/21 dining assistance (DA) M was educated by DON on why she should not be feeding resident 9 and how to determine who she can assist with feeding to avoid any immediate jeopardy to resident 9.<br>On 7/21 all nursing staff were educated by DON on the appropriate use of DA and not feeding anyone with an altered diet. DA were educated to check in with the charge nurse upon shift.<br>On 7/29/21 all nursing staff and DA were educated by DON on the residents they can/cannot feed and this list was posted in the med room out East hall and med room in the MCU. The list will updated and maintained by the charge nurse.<br>Care plans on all residents eligible for feeding assistance were updated by 8/3/21<br><br>All nursing staff will be educated on when the interdisciplinary team identifies the need for an altered diet, the order is updated and initiated. When order is initiated the charge nurse will enter the updated intervention into the care plan. The charge nurse then updates the list of residents needing assistance by either DA or CNA, hanging in both med rooms by 9/3/21.<br><br>DON or designee will do monthly audits on log of diet changes against care plan and list of residents DA can/cannot feed.<br><br>DON or designee will conduct direct observation audits once weekly for the first four weeks and monthly thereafter in East hall and MCU dining rooms. Findings will be reported by the DON or designee to the QAPI committee monthly or until QAPI committee determines compliance has been reached. | 9/3/21 |

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| F 811 | Continued From page 12<br>was at risk for aspiration. Findings include:<br><br>1. Observation on 7/13/21 at 5:15 p.m. in the memory care unit (MCU) revealed residents 3 and 27 had received dining assistance.<br><br>2. Observation and interview on 7/14/21 at 5:20 p.m. in the MCU dining room with dining assistant M feeding resident 9 revealed she:<br>*Received dining assistant training and worked in that capacity about two years.<br>-Was not a certified nurse aide.<br>*Nursing staff had told her if there were any residents she was unable to feed.<br>-There were no residents currently in the MCU she was restricted from feeding.<br>*Confirmed the water she helped resident 9 drink was thickened because he sometimes coughed when he drank water.<br><br>Interview on 7/14/21 at 4:45 p.m. with registered nurse D regarding the dining assistance program revealed:<br>*She was responsible for the dining assistant education program.<br>*Residents not eligible for dining assistance included those with swallowing difficulties, feeding tubes, residents at risk for aspiration and those who required thickened liquids.<br><br>Interview on 7/14/21 at 5:30 p.m. with licensed practical nurse N regarding the dining assistant program revealed she:<br>*Was responsible for the oversight of the dining assistants and determined whether a resident was appropriate to be fed by a dining assistant.<br>*Stated there were no residents in the MCU who were ineligible for dining assistance. | F 811 | | |

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| F 811 | Continued From page 13<br>Review of resident 9's care record revealed:<br>*A physician's order dated 5/18/21 for nectar thick liquids.<br>*A speech language pathologist progress note dated 6/30/21 indicated resident 9's diet had been changed to nectar thick water because he coughed drinking water.<br><br>Review of resident 9's care plan last reviewed on 4/29/21 revealed:<br>*His diet was regular with small servings.<br>*A history of recurrent upper respiratory infections.<br>*A need for extensive assistance of one staff for eating.<br><br>Interview on 7/15/21 at 10:15 a.m. and 11:05 a.m. with director of nursing (DON) B regarding the dining assistant program revealed:<br>*Residents excluded from this program included those who required thickened liquids or had a modified diet texture such as puree.<br>*She was not aware resident 9 had orders for thickened water.<br>-Dining assistant M should not have been allowed to feed him.<br>*Dining assistants relied on nursing staff to advise them of those residents they should not feed.<br>*She confirmed resident 9's care plan had not been updated to reflect current diet orders.<br>*The appropriateness of residents 3, 9, and 27 for dining assistance had not been identified in their care plans.<br><br>A dining assistance program policy was requested of administrator A on 7/15/21 at 8:10 a.m. On that same date at 11:45 a.m. DON B stated they had no policy. | F 811 | | |

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| F 842<br>F 842<br>SS=E | Continued From page 14<br>Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, | F 842<br>F 842 | Support specialist and all nursing staff will be educated on process by which facility will receive updated Hospice care plans. Hospice staff will fax nursing home support specialist update care plan on same day each week. This is given to the charge nurse and placed into the Hospice binder. Any changes to the plan of care will be communicated to MDS RN to update facility plan of care. DON will educate staff on the process. | 9/3/21 |

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| F 842 | Continued From page 15<br>medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 40053<br>Based on record review and interview, the provider failed to have a system in place to ensure complete and accurate resident medical records for one of one sampled residents (23) who received hospice services through one of one hospice agency. Findings include:<br><br>1. Review of resident 23's medical record | F 842 | | |

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| F 842 | Continued From page 16<br>revealed:<br>*She had been admitted to hospice on 2/17/21.<br>*Her care plan had not been updated to include her hospice admission until 3/5/21.<br>*Her care plan included:<br>-"Problems<br>-1) Spiritual [name of resident] and her family will be given the opportunity to express their faith and feelings within context of their faith tradition.<br>-2) [Resident's name] pain will be minimized within the limits of the disease.<br>-3) Symptoms problematic to [resident's name] will be addressed to maintain optimal quality of life."<br>*No interventions had identified what hospice services were provided, how often hospice services were to have been in the facility, or how hospice care was used.<br><br>1. a. Refer to F849. | F 842 | | |
| F 849 SS=E | Hospice Services<br>CFR(s): 483.70(o)(1)-(4)<br><br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.<br><br>§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in | F 849 | | |

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| F 849 | Continued From page 17<br>paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:<br>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.<br>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:<br>(A) The services the hospice will provide.<br>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.<br>(C) The services the LTC facility will continue to provide based on each resident's plan of care.<br>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.<br>(E) A provision that the LTC facility immediately notifies the hospice about the following:<br>(1) A significant change in the resident's physical, mental, social, or emotional status.<br>(2) Clinical complications that suggest a need to alter the plan of care.<br>(3) A need to transfer the resident from the facility for any condition.<br>(4) The resident's death.<br>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. | F 849 | **On 7/14/21 Hospice binder was created for resident 23 that includes the most recent plan of care, hospice election form, physician certification of the terminal illness, names and contact information for Hospice personnel involved in the patient's care, instructions on how to access the Hospice's 24 hour on-call system, Hospice medication information and Hospice physician and attending physician orders specific to each hospice patient.**<br><br>**DON or designee will conduct audits to ensure the necessary pieces to the Hospice binder are updated regularly by hospice staff, weekly for the first four weeks and monthly thereafter. Findings will be reported by the DON or designee to the QAPI committee monthly or until QAPI committee determines compliance has been reached.**<br><br>**On 7/14/21 Hospice Care intervention was added and implemented to resident 23's chart.** | **9/3/21** |

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| F 849 | Continued From page 18<br>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.<br>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.<br>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.<br>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. | F 849 | **On 7/21/21 Hospice education was given to all nursing staff by DON on the Hospice Care Intervention being added and implemented to resident 23's chart. Hospice staff will consult with charge nurse at every visit, updating on any changes to status or plan of care. This communication will be entered into the Hospice Care Intervention by charge nurse. Nursing staff will chart any phone conversations with Hospice staff in the "hospice notification" section of intervention.**<br><br>**DON will educate the Hospice staff by 9/3/21 on the expectation they will check in with the charge nurse after every visit.** | |

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| F 849 | Continued From page 19<br>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.<br>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient.<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice | F 849 | **Audits to ensure the Hospice Care Intervention is being completed will be done by the DON or designee weekly for the first four weeks and monthly thereafter. Findings will be reported by the DON or designee to the QAPI committee monthly or until QAPI committee determines compliance has been reached.** | |

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| F 849 | Continued From page 20<br>personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient.<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 40053<br>Based on record review and interview, the provider failed to ensure an integrated plan of care had been developed for one of one resident (23) receiving hospice services. Findings include:<br><br>Review of resident 23's medical record revealed:<br>*She had been admitted to hospice on 2/17/21.<br>*Her care plan had not been updated to include her hospice admission until 3/5/21.<br>*Her care plan included:<br>-"Problems<br>-1) Spiritual [name of resident] and her family will be given the opportunity to express their faith and feelings within context of their faith tradition. | F 849 | | |

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| F 849 | Continued From page 21<br>-2) [Resident's name] pain will be minimized within the limits of the disease.<br>-3) Symptoms problematic to [resident's name] will be addressed to maintain optimal quality of life."<br>*No interventions had identified what hospice services were provided, how often hospice services were to have been in the facility, or how hospice care was used.<br><br>Interview on 7/15/21 at 8:15 a.m. with director of nursing (DON) B regarding hospice revealed:<br>*DON B confirmed she had been designated as the point of contact between the provider and the hospice agency.<br>*There were no hospice binders for residents receiving hospice care.<br>*Hospice care plans were to have been faxed to the facility and those care plans should have been placed into the facilities care plan binder.<br>-That had not been done.<br>*She stated they did not have a procedure in place to ensure information was being received by hospice services.<br>*All hospice information had been received verbally from the hospice nurse when she visited.<br>*DON B had been unable to locate the resident's hospice care plan or any documentation from hospice for any visits hospice had completed for resident 23.<br>*DON B was unaware of how often the hospice nurse or aide visited resident 23.<br>-She stated it was dependent on the phase the hospice resident was in.<br>--She also stated she could find out the days hospice visited resident 23 if I wanted her to.<br>*DON B confirmed resident 23's plan of care had not been developed a collaborative plan of care but should have been. | F 849 | | |

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 |
|---|---|---|---|
| | 43A113 | A. BUILDING _____ B. WING _____ | 07/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVERA OAHE** MANOR | **700 E GARFIELD GETTYSBURG, SD 57442** |

| (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 |
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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 |
|---|---|---|---|
| | 43A113 | A. BUILDING _____ B. WING _____ | 07/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVERA OAHE MANOR | 700 E GARFIELD GETTYSBURG, SD 57442 |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>Surveyor: 18087<br>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 on 7/13/21. Avera Oahe Manor was found in compliance. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Livermont
TITLE: Administrator
(X6) DATE: 8/4/21

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.

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 |
|---|---|---|---|
| | 43A113 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVERA OAHE MANOR** | **700 E GARFIELD**<br>**GETTYSBURG, SD 57442** |

| (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<br><br>Surveyor: 18087<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/13/21. Avera Oahe Manor was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K293, K324, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 241 SS=C | Number of Exits - Story and Compartment<br>CFR(s): NFPA 101<br><br>Number of Exits - Story and Compartment<br>Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment.<br>18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and document review, the provider failed to maintain acceptable exits from each floor level of the building. The basement storage area had only one exit. Findings include:<br><br>1. Observation on 7/13/21 at 3:50 p.m. revealed the basement storage area did not have the required number of acceptable exits. It had only | K 241 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Livermont
TITLE: Administrator
(X6) DATE: 8/4/21

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.

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 |
|---|---|---|---|
| | 43A113 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVERA OAHE MANOR** | **700 E GARFIELD**<br>**GETTYSBURG, SD 57442** |

| (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 241 | Continued From page 1<br>one exit that discharged onto the main level corridor. The exterior exit discharge location was not apparent at the corridor level location from the basement stair enclosure. The basement storage area was adjacent to the boiler room (a hazardous location) that could not be designated as an approved emergency egress path. Review of previous survey data confirmed that condition had existed since the original construction.<br><br>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.<br><br>This deficiency would not affect any of the residents and minimal staff within the facility. | K 241 | | F |
| K 324<br>SS=D | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the | K 324 | | |

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 |
|---|---|---|---|
| | 43A113 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVERA OAHE MANOR** | **700 E GARFIELD**<br>**GETTYSBURG, SD 57442** |

| (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 324 | Continued From page 2<br>corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 18087<br>Based on document review and interview, the provider failed to conduct the required every six-months inspection of the cooking facility's fire suppression system for the range hood. The records regarding the kitchen hood fire suppression system indicated an inspection had been last done in September 2020. Findings include:<br><br>1. Document review on 7/13/21 at 4:00 p.m. of the kitchen hood fire suppression system records indicated the inspections had been performed in September 2020. The kitchen hood fire-suppression system must be inspected not less than every six months. There was no further documentation indicating other required inspections had taken place.<br><br>Interview with the administrator at on 7/13/21 at 4:45 p.m. confirmed that finding. She stated she would have the contractor perform the required inspection as soon as possible.<br><br>This deficiency affected one of numerous kitchen hood fire suppression system requirements. | K 324 | DVL Fire and Safety was contacted on 7/14/21 and came to the facility on 7/15/21 to perform inspection of kitchen hood. System was found to be in proper working order. Next inspection is due 1/22.<br><br>The every six month inspection was added to the Preventative Maintenance schedule. Audits will be conducted every 6 months by Administrator or designee and reported out to QAPI for further review and recommendation and/or continuation/discontinuation. | 9/3/21 |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 43A113 | A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____ | **7/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVERA OAHE MANOR** | **700 E GARFIELD GETTYSBURG, SD** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **K 293** | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and interview, the provider failed to ensure exit signage marked the path of egress for one of one locations (west exit from the nursing home). Findings include:<br><br>1. Observation on 7/13/21 at 3:15 p.m. revealed one exit sign located in the west end of the service wing corridor was turned 180 degrees so the illuminated part of the sign was not visible in the path of egress. The lamps in the fixture had also been removed. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the exit path had been diverted during the construction of the new hospital building. The hospital began seeing patients in December 2020. The exit sign had not been returned to the correct position for the approved egress path.<br><br>The deficiency affected 100% of the occupants. |
| **K 923** | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure.<br>Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO |

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The above isolated deficiencies pose no actual harm to the residents

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 43A113 | A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____ | **7/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVERA OAHE MANOR** | **700 E GARFIELD GETTYSBURG, SD** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **K 923** | Continued From Page 1 |

SMOKING."
Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion.
Cylinders stored in the open are protected from weather.
11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)
This REQUIREMENT is not met as evidenced by:
Surveyor: 18087
Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored on racks within five feet of the oxygen cylinders in the memory care sprinkler riser room. Findings include:

1. Observation on 7/13/21 at 4:15 p.m. revealed combustible materials were found to be stored adjacent to and within five feet of the 25 oxygen e cylinders stored in the memory care sprinkler riser room. The minimum five feet of separation between combustibles and oxygen storage was not maintained as required in this area.

The deficiency affected one of four smoke compartments.

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10624 | A. BUILDING: _____ B. WING _____ | 07/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVERA OAHE MANOR | 700 E GARFIELD AVE GETTYSBURG, SD 57442 |

| (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<br><br>Surveyor: 40788<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/13/21 through 7/15/21. Avera Oahe Manor was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 40788<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/13/21 through 7/15/21. Avera Oahe Manor was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Livermont

TITLE: Administrator

(X6) DATE: 7.29.21

STATE FORM 55899 HHIJ11 If continuation sheet 1 of 1