STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	4513 SOUTH PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103

(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
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/28/23 through 3/30/23. Avera Prince of Peace was found not in compliance with the following requirements: F812 and F880.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure their policies had been followed for monitoring and documenting food temperatures prior to meal services to ensure safe food temperatures in three of four kitchenettes. Findings include:	F 812	The staff identified for deficient practice were given individual instruction by the Support Services Manager on 4/19/23 on monitoring and documenting food temperatures before serving resident meals. Food service staff will be given education on the Food Temp Policy by the Support Services Manager during huddles on 4/24/23, 4/25/23, 4/26/23, 4/27/23 and 4/28/23 on monitoring and documenting food temperatures. All other staff will be given education by the Administrator or Director of Nursing on the Food Temperature policy at the all staff in-service on 5/4/23, 5/5/23, 5/8/23 and 5/9/23. Special focus will be given on safe food temperatures, taking food temperatures and documentation of food temps. The Support Services Manager will conduct audits 3 times weekly for 8 weeks to ensure appropriate food is being temped according to policy. The Support Services Manager will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	5-14-23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Hinker
TITLE: Administrator
(X6) DATE: 4-20-23

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 812	Continued From page 1	F 812		

1. Observation and interview on 3/30/23 at 8:34 a.m. on the first floor's Arrow Head and Boulder Creek kitchenette with server F revealed:
*When asked about her tasks, she stated there were checklists that guided her work.
*She would document the meal's food temperatures in the binder located in the kitchenette.

Review of the white, three-ring binders temperature log sheet labeled "March '23 1st [floor]" revealed:
-Breakfast temperatures were recorded except for the six food items on 3/20/23.
-Supper temperatures for food items were not recorded for 14 of 29 meals in March 2023.

2. Review on 3/30/23 at 11:09 a.m. on the second floor's Platinum Ridge and Bluegrass Way kitchenette revealed a white three-ring binder, similar to the binder on the first floor's kitchenette revealed:
*A temperature log sheet labeled "Platinum Ridge & Bluegrass Way" with "March 2nd [floor]" contained documentation of:
-Breakfast temperatures for the food items were not recorded for 6 of 30 meals in March 2023.
-Lunch temperatures for the food items were not recorded for 8 of 29 meals in March 2023.
-Supper temperatures for the food items were not recorded for 15 of 29 meals in March 2023.
3. Observation and interview on 3/29/23 at 9:35 a.m. on the rehabilitation floor kitchenette with server G revealed she:
*Used checklists to ensure she completed her kitchen tasks.
*Had to get the temperature of each food item before serving the food.
*Documented the temperatures of the food in the

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F 812	Continued From page 2	F 812		

white three-ring binder for the rehab unit.
*Agreed there was missing documentation for food temperatures in the binder.

Review of the white, three-ring binder's temperature log sheet labeled "March Rehab" revealed:
*Breakfast temperatures for food items were not recorded for 13 of the 29 meals to date in March.
*Lunch temperatures for food items were not recorded for 13 of the 28 meals to date in March.
Supper temperatures for food itmes were not recorded for 17 of the 28 meals to date in March.

4. Interview on 3/30/23 at 1:04 p.m. with support services manager E regarding the monitoring and documentation of food temperatures revealed she:
*Agreed and confirmed the policy instructed staff to have taken and recorded food temperatures for each meal on each of the provider's four kitchenettes.
*Stated her expectation was the nutrition service server assigned to each kitchenette would have taken and recorded the food temperatures prior to each resident meal service.

Continued interview with support services manager E regarding the food temperature logs for March 2023 from three of the four kitchenettes revealed she could not provide documentation for the food temperatures for any of the hot food items that were not recorded.

5. Review three of the four white, three-ring binders in the provider's kitchenettes revealed:
*The sheet on the front of the binder was titled "Temperature" and stated:
-"ALL foods MUST have the temperature taken

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F 812	Continued From page 3 and written down on the temperature log prior to serving." -"This needs to be recorded on the sheet each shift." -The bottom of the sheet had the first and last name of the support services manager E and the date "12.28.21[.]" Review of the provider's April 2021 policy on "Food Temperatures" revealed: *The purpose was to serve "safe and palatable foods." *The policy was "To keep food safe[.]" *The procedure included "Hot food temperature will be taken before placed in the steam table and recorded ..." Review of the October 2021 "Support Services Manager" job description revealed: *The summary included "Responsible for the overall daily operations, to assure quality services to residents ..." *Supervisory responsibilities included " ...planning, assigning, and directing work; appraising performance; ...resolving problems." *Essential functions included "Provides for the analysis, collection and maintenance of records ..."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 4 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	Corrective Action: 1. 1. For the identification lack of: *Appropriate hand hygiene when removing/changing personal protective equipment. *Appropriate hand hygeine and glove use during personal cares. *Appropriate maintenance and handling of Foley catheter when providing cares for resident. 2. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures by 4/21/23 for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/reeducated by 4/28/23 by the Administrator, Director of Nursing or Infection Control Supervisor. Identification of Others: 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate processes and follow through for hand hygiene and glove use in isolation rooms, catheter care and personal cares. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 4/28/23 by the Administrator, Director of Nursing or Infection Control Supervisor. Nursing staff were educated on hand hygiene, glove use, and appropriate maintenance and handling of Foley catheter during daily staff huddles on 4/24, 4/25, 4/26, and 4/27.	4-28-23

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F 880	Continued From page 5 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure proper infection prevention and control practices for the following: *One of one RN coordinator (I) exited resident 80's airborne isolation room and had not performed hand hygiene after removing his N95 mask and prior to putting on a surgical mask. *Glove use and hand hygiene for one of one registered nurse (RN) (J) and one of one licensed practical nurse (LPN) (H) while providing personal care for one of one sampled resident (48) who was on contact precautions for Klebsiella pneumoniae (a gram-negative bacteria) in her urine. *Handling a Foley catheter bag by one of one LPN (H) while transferring and providing cares for one of one sampled resident (48) who was on contact precautions for Klebsiella pneumoniae (a	F 880	3. System Changes: Root Cause analysis conducted on proper hand hygiene and answered the 5 Whys. The root cause analysis revealed staff needed to take a more methodical approach and take resident cares step by step to avoid mistakes. Administrator, DON, Education Supervisor, and Infection Control Supervisor will ensure ALL facility staff responsible for the assigned tasks have received education/training with demonstrated competency and documentation. Administrator, DON and Infection Control Supervisor have a meeting scheduled with the South Dakota Quality Improvement Organization (QIN) on 4-28-23. Discussion topics and agenda items will include our root cause analysis, plan of correction and monitoring/audit plan.	4-28-23

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F 880	Continued From page 6 gram-negative bacteria) in her urine. Findings include: 1. Observation on 3/30/23 at 7:45 a.m. of RN coordinator I after exiting resident 80's airborne isolation room revealed: *He had performed hand hygiene and removed his N95 mask. *He had touched the front of the N95 mask while placing the mask into the garbage. *Without performing hand hygiene, he opened a drawer on the three-drawer container next to the room door, took out a surgical mask, and placed the surgical mask on his face. Interview on 3/30/23 with RN coordinator I directly after the above observation revealed he agreed he should have performed hand hygiene after removing his N95 mask and before placing a new surgical mask on his face. 2. Observation on 3/28/23 at 4:35 p.m. of RN J and LPN H providing personal care for resident 48 in her room revealed: *They both had been wearing a gown, gloves, and a face mask. *They both transferred resident 48 from the recliner into her bed with a total body mechanical lift. *Resident 48 had been incontinent of her bowels. *RN G: -Performed incontinence care for resident 48 and without removing his gloves or performing hand hygiene he applied barrier cream to the resident's clean buttocks. -Changed his gloves and had not performed hand hygiene. -Cleaned resident 48's abdominal fold and removed his gloves.	F 880	Monitoring: 4. Administrator, DON, Assistant Director of Nursing or Infection Control Supervisor will conduct auditing and monitoring for proper glove use, hand hygiene and appropriate Foley catheter bag management. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. Staff compliance in the above identified area. Any other areas identified through Root Cause Analysis. Audits of proper PPE removal, hand hygiene and catheter bag management will be conducted 3 times weekly for 8 weeks by the Administrator, DON, ADON, or Infection control supervisor making observations across all shifts to ensure staff compliance with appropriate PPE use. * Monitoring results will be reported by administrator, DON, ADON, and/or Infection Control nurse to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director. The QAPI committee will direct further audits.	

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F 880	Continued From page 7	F 880		

-Without performing hand hygiene, he assisted LPN H position resident 48 in the bed.
-Without performing hand hygiene he placed a new pair of gloves on his hands.
-Adjusted the height of the bed, replaced the pillowcases on the pillows, and positioned resident 48 in bed to make her comfortable.
*LPN H:
-Held resident 48's Foley catheter bag above the level of resident 48's bladder while transferring her from the recliner to the bed with the total body mechanical lift.
-Placed the Foley catheter bag on the floor next to the bed by her feet.
-Assisted RN J with positioning the resident for personal care.
-Performed peri care for resident 48.
-Picked up the Foley catheter bag from off the floor and set it into a pink plastic basin on the floor.
-Changed her gloves without performing hand hygiene.
-Standing where the catheter bag had been on the floor, she assisted RN J position the resident in bed.
-Put the resident's protective boots on her feet.
-Without performing hand hygiene, changed her gloves, connected resident 48's tube feeding, and then turned on the feeding pump.

Interview on 3/28/23 after the above observation with RN J and LPN H regarding glove use, the Foley catheter bag, and appropriate hand hygiene revealed:
*They both agreed the Foley catheter bag should have been kept below the level of the bladder.
*They both should have performed hand hygiene when they were moving from a dirty task to a clean task and changing gloves before and after

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use.
*The pink plastic basin was used so the Foley catheter bag had not touched the floor.
*The Foley catheter bag should have been placed in the pink plastic basin once the resident was transferred into the bed and not placed on the floor where staff were standing.

3. Interview on 3/28/23 at 5:17 p.m. and again on 3/30/23 at 3:00 p.m. and 4:31 p.m. with director of nursing (DON) B regarding the above observations revealed:
*RN coordinator I should have performed hand hygiene after removing his N95 mask and prior to placing a new surgical mask on his face.
*He expected all staff to perform hand hygiene when moving from a dirty task to a clean task and before and after glove use.
*Agreed staff should have kept the Foley catheter bag below the level of the resident's bladder and the Foley catheter bag should not have been placed on the floor.

4. Review of the provider's July 2022 Hand Hygiene policy revealed staff should have performed hand hygiene after contact with body fluids, potentially contaminated surfaces, a resident, a resident's environment, and after removing gloves.

Review of the provider's March 2023 Indwelling Catheter Care policy revealed:
*"Maintain unobstructed flow of urine
-Catheter bag and tubing must be below the level of the bladder at all times including transport or ambulation
-Catheter bag may not be place [placed] on the floor at any time"

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E 000	Initial Comments 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 from 3/28/23 through 3/30/23. Avera Prince of Peace was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Hinker
TITLE: Administrator
(X6) DATE: 4-20-23

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APR 20 2022

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South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/28/23 through 3/30/23. Avera Prince of Peace was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement 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 3/28/23 through 3/30/23. Avera Prince of Peace was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Hinker

TITLE: Administrator

(X6) DATE: 4-20-23

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