STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Mother Joseph Manor Retirement Community	**1002 NORTH JAY STREET , ABERDEEN, South Dakota, 57401**

(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
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/31/25 through 8/1/25. Areas surveyed included quality care related to a resident choking incident and following physician orders. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirement: F678	F0000	Facility policies reviewed by DON, Quality Nurse & Administrator: 1. LTC Code Status Policy and no changes needed. 2. Advance Directive Policy & Procedure and no changes needed. 3. LTC Emergency Response, CPR - Avera's LTC nurse revised this policy. Quality Nurse reviewed code status of current residents: DNR/DNI-Medical Treatment ok- 37 DNR- 9 Full code- 14 DNR/DNI- Comfort care- 15 DNR- Ok to intubate- 1 LPN involved in incident was re-educated on the three policies listed above on 8/27/25 and clarified the meaning of "DNR/DNI, Medical Treatment, Ok", reviewed resident right of Self Determination and informed nurse that they are unable to override a resident's code status. Provided education on communication with EMS and to provide copy of code status to EMS. All Licensed nurses will be reeducated on the above policies at nurse meeting (initial meeting scheduled 8/27/25) by the DON or designee; several meetings are scheduled to reach nurses on all shifts, by 9/12/2025. Education will include the resident's right to "Self-Determination". DON or designee will call all licensed nurses unable to attend the meeting and educate them by phone. If unable to connect to licensed nurse by phone the licensed nurse will be removed from the schedule and won't return to work until the education is completed. All licensed nurses will be educated on when to initiate CPR according to the resident's code status. Nurses will be trained to provide copy of the resident's code status to EMS. In the event of a choking episode, emergency response, or initiation of CPR, DON or designee will complete a case review to assess compliance with the LTC Code Status Policy. After completion of the first case study, the results will be reviewed with all licensed nurses by the DON or designee at mandatory licensed nurse meeting that will be scheduled no later then 14 days following first case study.	9/15/2025
F0678 SS = E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, and interview, the provider failed to withhold cardiopulmonary resuscitation (CPR) for one of one resident (1) with a do not resuscitate/do not intubate (DNR/DNI) code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) who experienced a choking episode, choked, and had no pulse or respirations after her airway was cleared. Findings include: 1. Review of the provider's 7/27/25 SD DOH FRI revealed: *On 7/27/25, resident 1 choked while eating her lunch. *The nurse was called over to the table where resident 1 had been eating and "finger swept" a large bite of meat out of resident 1's mouth and did "several back blows." *Staff members assisted resident 1 to stand, and the	F0678		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Henrickson	Administrator	8/27/2025

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F0678 SS = E	Continued from page 1 nurse did abdominal thrusts for “several minutes with no luck dislodging the food.” *”911 was called and the EMTs [emergency medical technicians] and police arrived within minutes” and “were able to remove a piece of meat from her [resident 1’s] throat using a camera and long pinchers.” *Resident 1’s daughter was called “several times by the nurses and police with no answer.” *“The EMTs started CPR (cardiopulmonary resuscitation) and transported” resident 1 to the hospital. *Resident 1’s “daughter was reached by phone and said she did not want CPR continued.” *Resident 1’s cause of death was “asphyxia [lack of oxygen] due to foreign body [an object in a part of the body where it does not normally belong] and cardiopulmonary arrest cardiopulmonary arrest [sudden, unexpected loss of heart function, breathing, and consciousness].” *”Resident 1’s code status was “DNR/DNI: Medical treatment OK.” 2. Review of resident 1's electronic medical record (EMR) revealed: *She was readmitted to the facility on 6/30/25 after a hospitalization on 6/23/25 for aspiration pneumonia (lung infection caused when substances, such as food, are inhaled into the lungs). *Her diagnoses included dysphagia (difficulty swallowing foods or liquids) and cerebral vascular accident (stroke). *Resident 1 had appointed her daughter as her Power of Attorney (someone designated on a legal document to act on behalf of a resident) (POA) *On 9/8/21, resident 1’s POA had signed a “NO CODE (Care and Comfort ONLY)” directive. *A 6/16/25 physician’s order for “DNR/DNI: Medical Tx [treatment] okay.” *A 6/30/25 physician’s communication “Resident [1] was re-admitted to [provider initials] today. She returned with orders for Nectar thickened liquids. [A] swallow	F0678	DON or designee will interview licensed nurses on resident’s code status and give them a scenario where the resident has no pulse and evaluate their response. Education will be provided if necessary. Three nurses will be interviewed 2x per week until all nurses have been interviewed and training provided to new licensed nursing. DON or designee will monitor for compliance. Deficiency and case review will be reviewed at QAPI for further recommendations until the facility demonstrates sustained compliance.	

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F0678 SS = E	Continued from page 2 study was done and no aspiration [was] noted. [The] report states [the] resident is safe to advance to [consume] thin liquids. [The] resident is refusing thickened liquids. Daughter [name omitted] is requesting the order be changed. Risk of aspiration reviewed with the resident and daughter. They are still asking to advance liquids to thin. May we have an order for thin liquids and also an order for ST [Speech Therapy] to follow?" *A 7/1/25 physician's order for "IDDSI [International Dysphagia Diet Standardization Initiative (a categorized food and drink consistency system)] 6 Soft and Bite-Sized Diet" and "thin liquids." *A 7/8/25 physician's order "OK for straws." *A 7/10/25 physician communication "May we have an order for [resident 1] to have bread products OK'd as an exception to [the resident's] IDDSI 6 soft and bite-sized [ordered diet]," was signed by the physician on 7/11/25 with the physician having added "agree w/ [with] above]." 3. Review of resident 1's 7/27/25 [Ambulance name] Prehospital Care Report Summary revealed: *An initial emergency call was received on 7/27/25 at 12:12 p.m. that resident 1 was choking, "not breathing and the Heimlich maneuver [a first-aid procedure for dislodging an obstruction from a person's airway] was being attempted." *The paramedics made contact with resident 1 at 12:17 p.m. as nursing home staff were assisting her to her room in her wheelchair. *Resident 1 was "unresponsive," had "weak radial (wrist) and carotid (neck) pulses," her dentures were removed, she did not respond to verbal or painful stimuli, and she did not have breath sounds. *She was moved from the wheelchair to the ambulance stretcher, and a video laryngoscope (a device used to visualize the throat and top of the windpipe) and forceps (a surgical tool resembling tongs with pincers) were used to remove "a chunk of meat from the epiglottis opening (the entrance of the windpipe) and clear her airway which was confirmed with the use of a Bag-Valve-Mask (BVM) (a device used to assist a person who is not breathing or breathing inadequately). *An i-gel (a medical airway device) was used to provide	F0678		

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F0678 SS = E	Continued from page 3 ventilation (rescue breaths). *Resident 1 was assessed by the paramedic after clearing her airway. She did not have a radial or carotid pulse and was hooked to a cardiac monitor. *The paramedic then confirmed with facility staff that the resident was a DNR/DNI, contacted the emergency medical doctor, and was instructed by that doctor to continue ventilation and to monitor the resident. *The paramedics were provided a copy of resident 1's DNR/DNI and were told by the facility nurse (licensed practical nurse (LPN) D) that "the daughter of the patient would wish for CPR in this case." *The paramedics initiated CPR and completed two rounds of CPR. A carotid pulse returned, and the resident was prepared for transport to the hospital. *Resident 1's daughter met the paramedics and the resident on the stretcher in the hallway on the way to the ambulance and "shares that this is not what the patient would [have] wanted (CPR)," and "she wished for no further resuscitation efforts." *The paramedics left the facility at 12:46 p.m. 4. Phone interview on 7/31/25 at 11:20 a.m. with LPN D, who worked on 7/27/25 revealed: *On 7/27/25, while serving residents lunch in the dining room, she was alerted by resident 1's tablemates that resident 1 needed help. *LPN D immediately identified that resident 1 was choking, did a "finger sweep," and started to perform the Heimlich maneuver. *911 was called immediately by food service worker E. *Food service worker E and certified nursing assistant (CNA) F assisted resident 1 to stand while LPN D continued to perform the Heimlich maneuver which was unsuccessful in dislodging any object from the resident. *Resident 1 became unresponsive and was being transported to her room in her wheelchair when the paramedics arrived. *Multiple attempts were made to get in contact with resident 1's daughter, who was her POA, by phone. LPN D	F0678		

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F0678 SS = E	Continued from page 4 had left a message that resident 1 had choked and she needed to come to the facility right away. *A paramedic had come out of resident 1's room to confirm what resident 1's code status was, and to obtain the code status form. *LPN D confirmed that resident 1 was a DNR/DNI, but that medical treatment was ok and stated that the daughter would want the resident to receive CPR. *LPN D thought it took about 45 minutes before resident 1's daughter was contacted. During that time, LPN D stated she left another message for resident 1's daughter notifying her that the paramedics needed to know if CPR should be initiated, and that she had said to start CPR. *When resident 1's daughter arrived, she was upset that CPR had been started. *LPN D recalled that the food remaining on resident 1's plate had been cut into small pieces. 5. Interview on 7/31/25 at 1:28 p.m. with registered dietitian G and hospitality director H revealed: *The lunch menu on 7/27/25 included cheesy mashed potatoes, sliced pork with gravy, a vegetable, and a dinner roll. *Resident 1 was on an IDDSI 6 Soft and Bite-Sized Diet, but she was allowed bread, thin liquids, and to use a straw. Her meat would have been cut before her plate was served to her. 6. Phone interview on 7/31/25 at 2:04 p.m. with resident 1's daughter revealed: *On 7/27/25 at 12:20 p.m., she had a missed call and voice message from the facility notifying her that her mother had choked and that she needed to come to the facility right away. *At 12:29 p.m., she called the facility and told them that she was coming to the facility. *At 12:31 p.m., she received a missed call and voice message from LPN D, stating that they needed her to call back "right away" because they knew that her mother's code status was DNR/DNI and they needed her approval to provide CPR, and that LPN D had told the	F0678		

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F0678 SS = E	Continued from page 5 paramedics that she (resident 1's daughter) would have wanted CPR started. *Resident 1's daughter confirmed that her mother's code status was DNR/DNI and that she had not wanted CPR started. *She arrived at the facility as the paramedics were transporting her mother (resident 1) to the ambulance at approximately 12:45 p.m. and questioned why CPR had been started when the facility staff had been aware that resident 1's code status was DNR/DNI. 7. Interview on 7/31/25 at 3:32 p.m. with administrator A and quality and infection prevention RN C revealed: *Resident 1's code status was DNR/DNI with an OK for medical treatment at the time of her choking incident on 7/27/25. *That the facility policy was that CPR was performed in response to a choking resident, even if a resident's code status was DNR/DNI for clearing of the airway. *The paramedics had taken over resident 1's care when they arrived. The paramedics were aware that resident 1 was a DNR/DNI, and the paramedics performed CPR on resident 1. *They were unsure if CPR had been started for resident 1 before or after resident 1's airway had been cleared. *LPN D did not have the authority to decide if CPR should have been performed for resident 1 when attempts to contact resident 1's daughter had been unsuccessful, even if that was what she thought resident 1 and her daughter would have wanted. *They confirmed that LPN D had not followed resident 1's physician-ordered DNR/DNI code status. 8. Review of the provider's 2/20/25 Advance Care Planning policy revealed: *"The goals of the advanced directive policy are to promote human dignity and self-determination, to ensure that patients' advance directives are honored, and to ensure compliance with the Patient Self-Determination Act of 1990." *The provider "honors a patient's right to make advance directives…"	F0678		

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F0678 SS = E	Continued from page 6 *"Advanced care planning allows the resident to consider and express their values, goals and wishes regarding care and treatment." *"Any…health care provider, and healthcare facilities shall comply with a person's EMS cardiopulmonary resuscitation directive that is apparent and immediately available." Review of the provider's 1/15/25 LTC [Long Term Care] Emergency Response, CPR policy revealed: *"If a resident with a DNR order has a choking episode that requires the Heimlich maneuver, at any point during the episode the resident ceases to have a pulse, in order to continue with the manual clearing of the airway, chest compressions will be applied until emergency personnel arrive and take over to care for the resident." *"If an advanced directive includes a request for a Do Not Resuscitate (DNR) order:… DNR orders are communicated to staff through documentation in the medical record and the patient's care plan."	F0678		