STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/9/25 through 9/11/25. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F554 and F880.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review the provider failed to ensure self-administration of medication assessments had been completed on two of three sampled residents (3 and 24) who self-administered medications were assessed for their ability to safely self-administer medications and the resident's care plans reflected that according to the provider's policy. Findings include: 1.Observation and interview on 9/9/25 at 8:55 a.m. of resident 3 in her room revealed: *She had opened her bedside stand drawer and there was a bottle of PreserVision AREDS (an eye supplement) and a bottle of Lutein (vitamin supplement) in the top drawer of the stand. *She indicated she took them occasionally, not every day. *There was no label indicating use on either bottle. Observation and interview on 9/9/25 at 9:47 a.m. with resident 24 in his room revealed:	F0554	The facility does ensure self-administration of medication assessments are completed to determine the resident's ability to safely self-administer medications. All residents are potentiall at risk.Resident 3 made decision to not use these medications so no self-administration assessment was completed. Resident 24 self-administration of medication assessment was completed on 9/11/25, and it was determined the resident was unable to self-administer the medication. Director of Nursing (DON) or designee will educate all nurses to notify the care plan team of resident request to self-administer medications. The care plan team will complete a self-administration assessment and if the resident is capable will obtain physician order and care plan accordingly. The in-service education will be completedby 10/23/25. DON or designee will complete audits weekly X 4 weeks then 2x monthly for 3 months to ensure a self-administration of medication assessment is completed prior to allowing the resident to self administer medications. Results of the audits will be reported by the DON or designee at the bi-monthly Quality Assurance Performance Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of the audits	10/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Talli Raske	Administrator	10/1/25

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F0554 SS = D	Continued from page 1 *There was a bottle of Fluticasone Propionate nasal spray sitting on his windowsill. *He said he had not used it in a couple of weeks. 2. Review of resident 3's electronic medical record (EMR) revealed: *Her Brief Interview for Mental Status (BIMS) assessment score dated 9/8/25 was 15 which indicated her cognition was intact. *There was no order for Lutein included in her current physicians' orders. *There was no order for PreserVision AREDS included in her current physicians' orders. *There was no self-administration medication assessment completed to determine the resident's ability to safely self-administer medications. Review of resident 24's EMR revealed: *His BIMS assessment score dated 6/23/25 was 10 which indicated his cognition was moderately impaired. *He had a 3/19/25 physician's order for him to self-administer his fluticasone propionate nasal spray. *There was no self-administration assessment completed to determine his ability to safely self-administer the fluticasone propionate medication. *His care plan did not indicate that he self-administration medications. 3.Interview on 9/11/25 at 8:31 a.m. with licensed practical nurse (LPN) G revealed: *If a resident wanted to self-administer medication an order was to be obtained from the doctor. *A nurse was to complete a self-administration assessment of the resident. *The intradisciplinary team (IDT) would make the final decision if the resident was able to safely self-administer the medication.	F0554		

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F0554 SS = D	Continued from page 2 *The resident's care plan was to be updated to reflect the resident's self-administration of medications. *She was not aware that resident 3 had medications in her room. *She was aware that resident 24 had an order dated 3/19/25 to self-administer his fluticasone propionate medication. *The self-administration of medications was then added to the worklist for the nurse to check off daily for the resident's that self-administered medications. Interview on 9/11/25 at 8:59 a.m. with registered nurse (RN)/Minimum Data Set (MDS) G revealed: *Floor nurses would sometimes initiate the self-administration assessment. *The resident was to be educated on administration safety and the medication. *The interdisciplinary team (a group of healthcare professionals who collaborate patient care) were to have an informal discussion about the resident's ability to safely self-administer the medication. *They were to then update the resident care plan to reflect that information. *Care plans were to be updated quarterly and as needed (PRN). Interview on 9/11/25 at 9:12 a.m. with director of nursing (DON) B regarding self-administration of medications revealed: *The nursing staff would communicate with the resident's physician to order medication self-administration if it was determined the resident could safely self-administer medication. *The nursing staff would identify if that medication should be stored at the resident's bedside or in the medication cart. *A self-administration assessment should be completed to determine the resident's ability to safely self-administer medication. -A member of the interdisciplinary team (IDT) or a	F0554		

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F0554 SS = D	Continued from page 3 floor nurse could complete that assessment. *The order for self-administration of medication would be added to the worklist for the floor nurse to check off daily. *The self-administration of medications was to be added to the resident's care plan. *She agreed resident 24 did not have a self-administration assessment completed. *She was unaware of the Lutein in resident 3's room that she was taking, until she was informed on 9/10/25. *She was unaware that resident 3 had PreserVision AREDS medication which she took occasionally, in her room. *She agreed that no self-administration assessment had been completed for resident 3. 4. Review of the provider's revised 2/2017 Self Administration of Medications policy revealed: *"Avera will utilize a centralized, standardized and managed process to assure Self Administration of Medications by residents who desire to do so provided the interdisciplinary team, including at least a physician, nurse, pharmacist, and social worker has determined the practice would be safe for the resident and other residents of the facility." *a. "If the resident desires to self-administer medications, an assessment is conducted and recorded in the Self Administration LTC intervention. The interdisciplinary team (IDT) will be involved in the assessment. They will assess the resident's cognitive, physical and visual ability to carry out this responsibility." *c. "All resident's approved for self-administration will have Self Administration addressed on the resident's care plan."	F0554		
F0880 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	F0880	The facility does ensure to follow infection control practices to ensure residents' catheter bags were not lying on the floor according to the provider's policy and nasal cannula tubing was disinfected or replaced before placing it on a resident's face. All residents are potentially at risk. Staff will ensure resident 7's catheter bag is covered and if nasal cannula tubing is found on the floor to replace with new tubing.	10/24/25

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F0880 SS = D	Continued from page 4 prevent the development and transmission of communicable diseases and infections. §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 §483.71 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 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.	F0880	The DON or designee will educate RN's, LPN's, and CNA's on the requirement to ensure that a catheter bag has a bag cover over it and to replace the nasal cannula for those residents' using oxygen if the nasal cannula falls on the floor.The in-service education will be completed by 10/23/25. DON or designee will complete 2 audits/ week X 4 weeks, then 2/month X 3 months to ensure catheter bags are covered and nasal cannula tubing is replaced after falling on the ground. Results of the audits will be reported by the DON or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of the audits.	

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F0880 SS = D	Continued from page 5 §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 follow infection control practices to ensure residents' catheter bags were not lying on the floor according to the provider's policy and nasal cannula (NC) tubing was disinfected or replaced before placing it on a resident's face for one of one sampled resident 7 observed with NC tubing and a catheter bag lying on the floor. Findings include: 1. Observation on 9/9/25 at 10:28 a.m. in resident 7's room, revealed the resident's catheter bag was lying on the floor next to her bed without a covering or a barrier under it. Observation on 9/9/25 at 12:17 p.m. in the dining room area revealed resident 7's catheter bag was uncovered and lying under her wheelchair, touching the floor. Observation on 9/9/25 at 2:29 p.m. in resident 7's room revealed her nasal cannula (NC) [flexible tubing with prongs that delivers oxygen through the nose] and oxygen tubing were lying on the floor. 2. Observation and interview on 9/10/25 at 8:40 a.m. with registered nurse (RN) H and licensed practical nurse (LPN) I in resident 7's room revealed: *Resident 7's NC tubing was lying on the floor and coiled under the wheel of her bedside table next to her bed. *Her catheter bag had a cover on it and was lying on	F0880		

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F0880 SS = D	Continued from page 6 the floor under her bed. *RN H had picked the NC tubing off the floor and used and wiped the NC prongs off with an incontinent care wipe and reapplied it to resident 7's face. *RN H confirmed that was her usual process for cleaning NC tubing found on the floor. *She knew it was considered dirty and wanted to ensure it was clean before putting it back on the resident. *She checked the electronic medical record (EMR) which indicated that resident 7's NC tubing had been changed last 22 days ago, and it was ordered to be changed every Monday at 2:30 p.m. *RN H exited the room and returned with new NC tubing for resident 7. *LPN I then picked resident 7's catheter bag up off the floor and hung it on the bed frame. Interview on 9/9/25 at 12:22 p.m. with resident aide (RA) E revealed that catheter bags should all be covered for privacy, and they should not be lying on the floor. Interview on 9/9/25 at 12:25 p.m. with LPN C revealed that catheter bags should have a covering on them, and they should not be lying on the floor. Interview on 9/11/25 at 11:11 a.m. with RN/Minimum Data Set (MDS)/infection preventionist (IP) J revealed: *When NC tubing was observed lying on the floor, she would expect it to be replaced with new tubing. *Catheter bags should not have been lying on the ground. -She expected catheter bags to be hung for drainage and covered for dignity whenever residents with catheter bags were outside of their rooms. 3. Review of the provider's revised 5/25 Respiratory Equipment policy revealed: *"Change oxygen tubing and mask per MIFU [manufacturer's instructions for use]."	F0880		

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F0880 SS = D	Continued from page 7 Review of the provider's revised 3/13/25 Perineal Care policy revealed: *"Purpose to provide best practice for perineal care to prevent skin breakdown and infection. D. Residents with an indwelling urinary catheter (IUC) e. Hang drainage bag: -Below the bladder. -Ensure bag is not touching the ground." 6."Urine collection bag… b. should not touch the floor." "d. the spout should never touch the floor..."	F0880	Type text here	

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E0000	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 on 9/10/2025. Avera Maryhouse Long Term Care was found in compliance.	E0000		10/24/25

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Talli Raske	Administrator	10/1/25

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K0000	INITIAL COMMENTS A recertification survey was conducted on 9/10/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Maryhouse Long Term Care Building 1 was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K531 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/15/25. Please mark an F in the completion date column for K226 deficiency identified as meeting the FSES.	K0000		
K0226 SS = C	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation, testing, interview, and document review, the provider failed to maintain ninety-minute horizontal exit doors in operating condition. The horizontal doors separating building 1 and building 2 on the second floor when closed provided a gap clearance between the door and the floor greater than three-quarters of an inch (3/4-inch). Findings include: 1. Observation and testing on 9/10/25 at 9:46 a.m. revealed the cross-corridor horizontal exit doors	K0226		F

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Talli Raske	Administrator	10/1/25

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K0226 SS = C	Continued from page 1 separating building 1 and building 2 on the second floor when closed failed to maintain the ninety-minute, fire-resistive rating of the assembly. The doors when closed provided a gap greater than 3/4-inch between the carpeted floor and the bottom of the door. NFPA 80 Article 3-6 indicates clearances should be no greater than 3/4-inch from the floor to the bottom of the door. Interview with the plant operations supervisor at the time of the above observation and testing confirmed that finding. He indicated the door had been adjusted but could not be lowered any further. Lowering the door further would cause it to catch on the floor when in the open position. If the door were to catch on the floor it could prevent the automatic self-closing mechanism from functioning. Review of the previous life safety code survey dated 3/19/24 confirmed the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K0226		
K0531 SS = B	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	K0531	The facility does maintain elevator safety requirements. All residents are potentially at risk. The west (number 1) elevator recall in building 1 was not tied in to the fire alarm system. Otis Elevator Company was contacted, they came and connected the recall condition for the west elevator to tie in to the fire alarm system on 9/29/25. Results of the west elevator repair will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations.	10/24/25

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K0531 SS = B	Continued from page 2 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on document review and interview, the provider failed to maintain elevator safety requirements for the west (number 1 OTIS) elevator by not having the elevator recall tied in to the fire alarm system. Findings include: 1. Document review on 9/10/25 at 2:00 p.m. revealed the annual fire alarm report dated 6/19/25 from Automatic Building Controls commented that the west (number 1) elevator recall in building 1 was not tied in to the fire alarm system. It stated the elevator company (OTIS) would need to land the wires to the fire alarm panel. Interview with the plant operations supervisor at the time of the document review confirmed that finding. He stated the annual elevator servicing had been performed in February 2025 and that the fire alarm panel for building 1 had been replaced after that work was completed. The elevator company had not been contacted to reconnect the recall condition for the elevator to the new fire alarm panel. The deficiency affected one of numerous requirements for elevator maintenance.	K0531		
K0712 SS = C Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on document review and interview, the provider failed to maintain the minimum number of required fire	K0712	The facility does maintain the minimum number of required fire drills and the required variation of the times the drills are held. All residents are potentially at risk. Administrator and or Maintenance Supervisor will educate the Maintenance Technician on the times of the facilities shifts worked to ensure fire drills are completed 1 per shift per quarter and to vary the times the drills are held. The in-service education will be completed by 10/23/25.	10/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0712 SS = C Bldg. 01	Continued from page 3 drills or the required variation of the times the drills were held. Findings include: 1. Document review on 9/10/25 at 2:15 p.m. revealed the nursing home was staffed with three shifts. Documentation of the fire drills since the last survey dated 3/19/24 were reviewed and revealed no third shift fire drill was held in the second quarter of 2024 (April, May, June) or the second quarter of 2025 (April, May, June). Drills must also be held at varying times for each shift. Seven second shift (1400 - 2200 hours) fire drill times, beginning in April 2024, were documented as having been held as follows: May 2024 - 1635 hours June 2024 - 1446 hours August 2024 - 1515 hours November 2024 - 1505 hours February 2025 - 1454 hours June 2025 - 1838 hours August 2025 - 1308 hours. Interview with the plant operations supervisor at the time of the document review confirmed those findings. The deficiency affected two of numerous requirements for fire drills.	K0712	Administrator or designee will complete monthly audits X 4 months to ensure fire drills are completed per the requirements and that the times of drills vary. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0000	INITIAL COMMENTS A recertification survey was conducted on 9/10/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Maryhouse Long Term Care Building 2 was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/15/25. Please mark an F in the completion date column for the K226 and K311 deficiencies identified as meeting the FSES.	K0000		
K0226 SS = C	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation, testing, interview, and document review, the provider failed to maintain ninety-minute horizontal exit doors in operating condition. The horizontal doors separating building 1 and building 2 on the second floor when closed provided a gap clearance between the door and the floor greater than three-quarters of an inch (3/4-inch). Findings include: 1. Observation and testing on 9/10/25 at 9:45 a.m.	K0226		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0226 SS = C	Continued from page 1 revealed the cross-corridor horizontal exit doors separating building 1 and building 2 on the second floor when closed failed to maintain the ninety-minute, fire-resistive rating of the assembly. The doors when closed provided a gap greater than 3/4-inch between the carpeted floor and the bottom of the door. NFPA 80 Article 3-6 indicates clearances should be no greater than 3/4-inch from the floor to the bottom of the door. Interview with the plant operations supervisor at the time of the above observation and testing confirmed that finding. He indicated the door had been adjusted but could not be lowered any further. Lowering the door further would cause it to catch on the floor when in the open position. If the door were to catch on the floor it could prevent the automatic self-closing mechanism from functioning. Review of the previous life safety code survey dated 3/19/24 confirmed the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K0226		
K0311 SS = C	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by:	K0311		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0311 SS = C	Continued from page 2 Based on observation and review of previous survey document records, the provider failed to maintain a protected path of egress. The east stair enclosure discharged past unprotected window openings. Findings include: 1. Observation on 9/10/25 at 1:15 p.m. revealed the exterior sidewalk and steps from the east exit stair enclosure discharged past unprotected window openings. Review of the previous life safety code survey confirmed that the condition had existed since the original construction. The deficiency affected one of numerous requirements for maintaining protected paths of egress. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety standards.	K0311		
K0712 SS = C Bldg. 02	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on document review and interview, the provider failed to maintain the minimum number of required fire drills or the required variation of the times the drills were held. Findings include: 1. Document review on 9/10/25 at 2:15 p.m. revealed the	K0712	See above Plan of correction building 1	10/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BUILDING 02** B. WING	(X3) DATE SURVEY COMPLETED **09/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA , PIERRE, South Dakota, 57501**

(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
K0712 SS = C Bldg. 02	Continued from page 3 nursing home was staffed with three shifts. Documentation of the fire drills were since the last survey dated 3/19/24 were reviewed and revealed no third shift fire drills were held in the second quarter of 2024 (April, May, June) or the second quarter of 2025 (April, May, June). Drills must also be held at varying times for each shift. Seven second shift (1400 - 2200 hours) fire drill times, beginning in April 2024, were documented as having been held as follows: May 2024 - 1635 hours June 2024 - 1446 hours August 2024 - 1515 hours November 2024 - 1505 hours February 2025 - 1454 hours June 2025 - 1838 hours August 2025 - 1308 hours. Interview with the plant operations supervisor at the time of the document review confirmed those findings. The deficiency affected two of numerous requirements for fire drills.	K0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0000	INITIAL COMMENTS A recertification survey was conducted on 9/10/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Maryhouse Long Term Care Building 3 was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321, K353, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/15/25. Please mark an F in the completion date column for K311 deficiency identified as meeting the FSES.	K0000		
K0311 SS = C	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and previous survey document review, the provider failed to maintain the one-hour, fire-resistive rating for three of three stair	K0311		F

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Talli Raske	Administrator	10/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0311 SS = C	Continued from page 1 enclosures (north and east of the activities room and the southeast stairs). Findings include: 1. Observation on 9/10/25 revealed three stair enclosures with doors without a label identifying their fire-resistive rating. Those doors were 1 and three-quarters of an inch (3/4-inch) hollow metal doors. The doors led: *To the stair enclosures north of the activities room on the first and second floors. *To the stair enclosures east of the activity room on the first and second floors. *To the southeast stair enclosures on the first and second floors. Review of the previous life safety code survey dated 3/19/24 confirmed that the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety standards.	K0311		
K0321 SS = B	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K0321	The facility does maintain proper door closures on storage room doors. All residents are potentially at risk. Storage room #3 door on the ground floor had a self-closing device installed 9/25/25. Results of the installation of the self-closing device on storage room door #3 will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and/or recommendations.	10/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0321 SS = B	Continued from page 2 Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain one of one randomly observed storage room (ground floor east #3) as required. Findings include: 1. Observation on 9/10/25 at 9:35 a.m. revealed the ground floor east storage room #3 was over 100 square feet in area and contained copious amounts of combustible items (plastic storage totes, cardboard boxes, and wood shelving). The 45-minute fire-rated door was not equipped with a self-closing device. Interview with the plant operations supervisor at that same time confirmed those findings. He stated the room had previously been used as an office.	K0321		
K0353 SS = B	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0353 SS = B	Continued from page 3 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain the automatic sprinkler system as required (missing ceiling tiles in ground floor maintenance area). Findings include: 1. Observation on 9/10/25 at 9:40 a.m. revealed the ground floor maintenance room had three missing two-feet by four-feet lay-in ceiling tiles. The automatic fire sprinklers would not function as designed since heat would escape above the lay-in ceiling through the missing tile locations. Interview with the plant operations supervisor at that same time confirmed those findings.	K0353	The facility does maintain the automatic sprinkler system as required by ensuring ceiling tiles are in place. All residents are potentially at risk. The 3 missing ceiling tiles in the ground floor maintenance area were replaced on 9/12/25. Administrator and or Maintenance Supervisor will educate the Maintenance Technician of the regulation to maintain the automatic sprinkler system by ensuring ceiling tiles are in place. The in-service education will be completed by 10/23/25. Results of the replaced ceiling tiles will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations.	10/24/25
K0712 SS = C Bldg. 03	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times	K0712	See above plan of correction building 1. Same Plan of correction	10/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA , PIERRE, South Dakota, 57501

(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
K0712 SS = C Bldg. 03	Continued from page 4 under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on document review and interview, the provider failed to maintain the minimum number of required fire drills or the varying of the times the drills were held. Findings include: 1. Document review on 9/10/25 at 2:15 p.m. revealed the nursing home was staffed with three shifts. Documents for fire drills were reviewed since the last survey dated 3/19/24. There was no documentation a third shift fire drill was held in the second quarter of 2024 (April, May, June) or the second quarter of 2025 (April, May, June). Drills must also be held at varying times for each shift. Of seven drills held for the second shift (1400 - 2200 hours) beginning in April 2024, drills were held as follows: May 2024 - 1635 hours June 2024 - 1446 hours August 2024 - 1515 hours November 2024 - 1505 hours February 2025 - 1454 hours June 2025 - 1838 hours August 2025 - 1308 hours. Interview with the plant operations supervisor at the time of the document review confirmed those findings. The deficiency affected two of numerous requirements for fire drills.	K0712		

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
	10662	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 E DAKOTA PIERRE, SD 57501

(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 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 9/9/25 through 9/11/25. Avera Maryhouse Long Term Care was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/9/25 through 9/11/25. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: S157, S169, S206, and S301.	S 000	The facility does ensure to maintain exhaust ventilation. The exhaust ventilation was repaired for the three locations identified; lower level janitor's closet and two toilet rooms to the west of the janitor's closet on 9/29/25. All residents are potentially at risk.	10/24/25
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in three locations (lower level janitor's closet and two toilet rooms to the west of the janitor's closet). Findings include: 1. Observation and testing on 9/10/25 at 9:45 a.m. revealed the janitor's closet in the lower level	S 157	Administrator or Maintenance Supervisor will educate the Maintenance Technician of the requirement to maintain the exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. The in-service education will be completed by 10/23/25. Administrator or designee will complete 2 audits weekly X 4 weeks, then 3 monthly X 3 months to ensure exhaust ventilation system is working properly. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of the audits.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Talli Raske	Administrator	10/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10662	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 E DAKOTA PIERRE, SD 57501

(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 157	Continued From page 1 was equipped with overhead ductwork. Testing of the airflow at the diffuser revealed there was no air flow being exhausted at that location. The adjacent two toilet rooms to the west had the same ductwork going through those rooms. Testing of the airflow at the diffusers in those rooms revealed there was no air flow being exhausted at those locations. Interview with the plant operations supervisor at that same time confirmed those findings. He stated the plant ventilation systems were being checked weekly by maintenance. He thought a belt may have come off a rooftop unit for that ductwork. Investigation by the maintenance staff at 11:00 a.m. revealed the source of the exhaust ductwork and subsequent lack of airflow was not known.	S 157	The facility does ensure to lock, install or maintain door alarming for unattended exit doors. All residents are potentially at risk. The south door in the exercise room on the lower level had a lock installed on 9/29/25.	10/24/25
S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not	S 169	Administrator and or Maintenance Supervisor will educate the Maintenance Technician to ensure any unattended exit door is either monitored, alarmed or locked. This in-service education will be completed by 10/23/25. Administrator or designee will complete 1 audit/week X 4 weeks, then 2 audits/ month X 3 months to ensure this door is locked. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10662	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 E DAKOTA PIERRE, SD 57501

(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 169	Continued From page 2 met as evidenced by: Based on observation and interview, the provider failed to lock, install or maintain door alarming for one randomly observed door (south corridor door of the exercise room). Findings include: 1. Observation on 9/10/25 at 10:00 a.m. revealed the south door of the lower-level exercise room opened into the egress corridor to the Parkwood independent living building. The door was not locked or alarmed. Residents could pass through the door to an egress corridor which was unlocked, and marked EXIT and two other doors that provided an exit from the building into another occupancy. 2. Interview with the plant operations supervisor on 9/10/25 at 10:05 a.m. confirmed those conditions.	S 169		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights;	S 206		

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S 206	Continued From page 3 (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview the provider failed to ensure the required new hire training (fire prevention and response, emergency preparedness procedure, infection prevention and control, accident prevention safety procedures, proper restraint use, resident rights, confidentiality of resident information, mandatory reporting incidents and diseases, care of residents with unique needs, dining assistance nutritional risks hydration, abuse neglect misappropriation mistreatment, and advanced directives) was completed within 30 days of hire for two of five employees (food service worker (FSW) D and resident aide E) reviewed. Findings include: 1. Review of the provider's employee personnel records for FSW D revealed: *He was hired on 2/3/25. *He had completed fire prevention and response,	S 206	The facility does ensure the required new hire training is completed within 30 days of hire. Staff D and E could not be corrected as they were past their 30 days of hire. All residents are potentially at risk. Administrator will educate DON and Food and Nutrition Manager that all healthcare personnel must complete the required new hire training with 30 days of hire. Administrator or designee will complete monthly audits X 4 months of all new hires to ensure the required new hire trainings are assigned and are completed within thirty days of hire. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of the audits.	10/24/25

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S 206	Continued From page 4 emergency preparedness procedure, infection prevention and control, accident prevention safety procedures, resident rights, confidentiality of resident information, mandatory reporting incidents and diseases, care of residents with unique needs, dining assistance nutritional risks hydration, abuse neglect misappropriation mistreatment, and advanced directives education on 6/5/25. * He had not completed proper restraint use education. *The training had not been completed within his first 30 days of hire. 2. Review of the provider's employee personnel records for resident aide (RA) E revealed: *She was hired on 3/31/25. *She had completed fire prevention and response, emergency preparedness procedure, infection prevention and control, accident prevention safety procedures, resident rights, confidentiality of resident information, mandatory reporting incidents and diseases, care of residents with unique needs, dining assistance nutritional risks hydration, abuse neglect misappropriation mistreatment, and advanced directives education on 5/7/25. *She had completed proper restraint use education on 5/22/25. *The training had not been completed within her first 30 days of hire. 3. Interview on 9/10/25 at 2:45 p.m. with administrator A revealed: *She agreed that FSW D and RA E had not completed the required training within their first 30 days of hire. *She was aware of the state requirement and would expect the training to be completed within 30 days of hire.	S 206		

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S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure two of five employees reviewed had completed the required dietary trainings (food safety, handwashing, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation) within 30 days of hire for food service worker (FSW) D, and annually for lead FSW F. Findings include: 1.Review of provider's employee personnel records revealed: *FSW D was hired on 2/3/25. *Lead FSW F was hired on 11/20/23. 2. Review of the provider's employee training records revealed:	S 301	The facility does ensure to complete the required dietary trainings within 30 days of hire and annually for food service workers. All residents are potentiallyat risk. Staff D training could not be corrected as he is past his 30 days of hire. Staff F no longer works at Avera St Mary's. Administrator will educate FNS Manager on the required dietary inservice trainings that are required and that the trainings must be completed within 30 days of hire and annually for all dietary or food-handling personnel. The in-service education will be completed by 10/23/25. FNS Manager or designee will complete monthly audits X 4 months to ensure all new hires have completed the required dietary trainings within 30 days of hire. A report will be run to check all annual education for FNS employees to ensure everyone is up to date with their education completion. Any employee that is not up to date will complete their trainings by 10/24/25. Results of the audits will be reported by the FNS Manager or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of the audits.	10/24/25

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S 301	Continued From page 6 *FSW D had not received training on food safety, handwashing, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation as of 9/11/25. *Lead FSW F had not received annual training on food safety, handwashing, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation since 1/2/24. 3. Interview on 9/10/25 at 2:45 p.m. with administrator A revealed: *She agreed that FSW D had not completed the required training on food safety, handwashing, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation within 30 days of hire. *She agreed that Lead FSW F had not completed the annual required dietary training on food safety, handwashing, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation since 1/2/24.	S 301		