DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

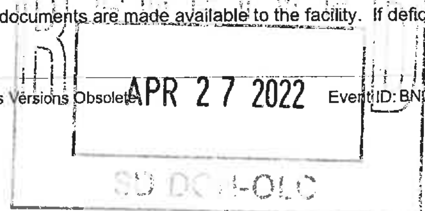
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING ______ B. WING ______	03/31/2022

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 Surveyor: 06365 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/29/22 through 3/31/22. Avera Prince of Peace was found not in compliance with the following requirements: F625, F636, F656, F689, F812, and F880.	F 000		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625	The 24 hour deadline to issue the bed hold policy for the residents identified has passed so we were not able to issue those notices. **Facility investigation noted lack of education and lack of inclusion on emergent transfer checklist. Education on bed holds is provided to staff on hire, however, the specific notification procedure was not included in that education. The emergent transfer checklist will be updated by 4/29/22 to include printing of behold notification and documentation that it was completed. The behold policy and emergent transfer checklist were added to the new hire orientation for all nursing and social work staff. Education will be provided by email by 4/29/22 to all nursing and social work staff prior to in person education at the all staff inservices. DON will provide education to social workers and RN Coordinators by 4/29/22 to check that bed hold notification was provided and documented the day after emergent transfer. Education was give to notify DON if not completed. (JH 4-27-22)** As a review, Administrator, Director of Nursing or Infection Control Supervisor will educate all staff on the requirement that bed holds are completed in written form within the 24 hour notice at the all staff inservice on 5/10/22, 5/11/22 and 5/12/22. The Assistant Director of Nursing will audit each transfer out of the facility for 8 weeks to ensure bed holds are being issued within the required 24 hour window. The Assistant Director of Nursing will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	5-13-22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Hinker
TITLE: Administrator
(X6) DATE: 4-22-22

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 625	Continued From page 1 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on interview, record review, and policy review, the provider failed to ensure notification of the bed hold policy had been provided to four of four sampled residents (3, 22, 28, and 91) upon transfer to the hospital. Findings include: Record of review of resident 3 revealed she: *Had been admitted to the hospital on 3/9/22 through 3/17/22 for respiratory distress. *Had not been provided with a bed hold notice nor had her representative. Record review of resident 22 revealed he: *Had been admitted to the hospital on 2/7/22 through 2/13/22 for a dialysis-related illness. *Had not received a bed hold notice nor had his representative. Record review of resident 28 revealed he: *Had been admitted to the hospital on 2/10/22 through 2/13/22 for surgical removal of ten fingers to both hands. *Had not received a bed hold notice nor had his representative. Record review of resident 91 revealed she: *Had been admitted to the hospital on 2/8/22 through 2/9/22 for a left total knee replacement. *Had not received a bed hold notice nor had her representative. Interview on 3/31/22 at 11:00 a.m. with director of nursing R revealed: *He had not been able to locate the bed hold	F 625		

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F 625	Continued From page 2 notices for resident 3, 22, 28, and 91. Review of the provider's Bed Hold Policy dated 12/21 revealed: *"The facility will provide to residents who are transferred to the hospital or go on a therapeutic leave, written information about the state's bed hold duration and payment amount before transfer." *"Residents and their representatives will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave." *"Nursing and social work staff are educated about the resident's bed hold and return rights to ensure that required information is provided at the time the resident leaves the facility."	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		5-13-22

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F 636	Continued From page 3 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636	The assessment and interventions for resident 33 were updated on 4/22/22 by the RN Coordinator. Assessments have been completed for all other residents who have similar behavioral conditions that require interventions. **The IDT team to include nursing, dietary, activities, social work, resident and/or resident representative will meet for a care conference following the completion of admission, annual or significant change MDS. All triggered CAAs will be reviewed including the Mood and Behavior CAA if applicable. Care Plan will be updated as needed following care conference. DON will provide education to the MDS Coordinators, dietary manager, and social workers on further assessing triggered items by 4/29/22. A request was placed with Avera IT on 4/26/22 to have charting software require documentation as to what occurred prior to documented behaviors. Currently, this is optional charting. Staff will be educated at all staff inservices to include what occurred prior to the behavior. (JH 4-27-22)** The Comprehensive Assessment/Care Plan Policy will be covered at the all staff inservice on 5/10/22, 5/11/22 and 5/12/22 on the need to complete assessments for residents who have health conditions that require staff intervention. The Assistant Director of Nursing will conduct 2 audits weekly for 8 weeks to ensure residents who have behavioral conditions requiring intervention have nursing assessments completed to identify the cause of the behavior. The Assistant Director of Nursing will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	

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F 636	Continued From page 4	F 636		

(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation, interview, and record review, the provider failed to fully assess the causes of behavioral symptoms for 1 of 21 sampled resident (33). Findings include:

1. Observation and interview on 3/30/22 at 11:07 a.m. revealed resident 33 responded with striking out when certified nursing assistant (CNA) S attempted to move her in a different direction than she was moving. CNA S explained the resident had dementia and "gets physical" when they interact with her. Refer to F689, finding 1.

Review of the 2/1/22 admission minimum data set (MDS) assessment of resident 33 revealed:
*Her admission date was 1/25/22.
*She had difficulty hearing and needed people to face her when speaking.
*She was able to state her basic needs and responded to simple and direct questions from others.
*She was rarely or never able to make decisions, was not able to maintain attention, and had rambling or incoherent thoughts.
*The mental status interview was not completed with the resident because she could not provide understandable responses.
*She completed the mood interview with a determination of moderate depression.
*She completed the preferences interview and stated it was "very important" to choose what to wear and what time to go to bed, to take care of her personal belongings, to have snacks available between mealtimes, to have access to reading materials, to listen to music, and be

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F 636	Continued From page 5	F 636		

around animals.
*Her behavior symptoms included having false beliefs and physical and verbal behaviors directed towards others that interfered with care, participation in activities and social interactions, and disrupted the care and living environment.
*She needed weight-bearing support from one person for the activities of daily living (ADLs) tasks of bed mobility, transferring between surfaces, and using the toilet.

Review of the Care Area Assessments (CAA) triggered from the answers coded on the 2/1/22 admission MDS revealed:
*The "CAA Summary" noted the location for the assessment information was "See intervention with the CAA prefix on Plan of Care 2/7/22."
*The "Mood State" CAA dated 2/7/22 noted the resident's mood score suggested "mild depression," which was not consistent with the coding on the 2/1/22 MDS.
*The "Behavioral Symptoms" CAA dated 2/7/22 noted:
-The resident's "dementia appears to cause her to misconstrue when staff attempts to help or redirect."
-She "attempts to protect herself by kicking, hitting, pinching, biting."
*The documentation for those CAAs did not address:
-Psychosocial changes such as her recent move into the nursing home.
-The relationship between her clinical conditions on her mood and behaviors.
-The indications, effectiveness, and potential side effects of the medications prescribed to impact her mood and behaviors.
-The seriousness of her behavioral symptoms.
-Previous lifestyle and customary routines and

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F 636	Continued From page 6 preferences. Review of the care plan for resident 33 started on 1/26/22 and reviewed on 3/4/22 revealed the lack of interventions for cognitive status, fall risk, elopement, behavior, and mood state. Refer to F656, finding 1. Interview on 3/31/22 at 3:45 p.m. with social worker V revealed: *It was "hard to determine what was causing her behaviors" since the documentation was not complete in that regard. *She agreed resident 33 needed to be approached from the front. *She had not written interventions on the care plan because she was still "new at doing care plans." *She wondered what could be done to deter her from going into others' rooms.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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F 656	Continued From page 7 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, the provider failed to develop person-centered care plans, and revise as needed, to address interventions for: *One of two sampled residents (33) for unsafe wandering. *One of four sampled residents (40) for falls. Findings include: 1. Observation and interview on 3/30/22 at 11:07 a.m. revealed resident 33 responded with striking	F 656	The care plans for resident 33 and resident 50 were updated on 4/22/22 by the RN Coordinator with updated interventions. All other residents who have similar behavior or falls have care plans that are current and reflect the current plan of care. The Comprehensive Assessment/Care Plan Policy will be covered at the all staff inservice on 5/10/22, 5/11/22 and 5/12/22 with special focus on the need to make sure all new and updated changes in condition and interventions are updated on the care plan. An interdisciplinary fall prevention meeting was started daily on 4/21/22 to look at the root cause of falls **and behaviors. To ensure individualized interventions address falls and behaviors, there will also be review at fall and behavior IDT to ensure care plan is updated with current interventions. (JH 4-27-22)** and implement any new interventions. The Assistant Director of Nursing will conduct audits 3 times weekly for 8 weeks to ensure care plans are current and up to date. The Assistant Director of Nursing will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	5-13-22

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F 656	Continued From page 8 out when certified nursing assistant (CNA) S attempted to move her in a different direction than she was moving. CNA S explained the resident had dementia and "gets physical" when they interact with her. Refer to F689, finding 1. Review of the 2/1/22 admission minimum data set (MDS) assessment of resident 33 revealed problems with cognitive status, mood and behavior, and falls, very important customary routines and preferences, and the need for assistance with the activities of daily living (ADLs) of bed mobility, transferring between surfaces, and using the toilet. Refer to F636, finding 1. Review of the care plan for resident 33 started on 1/26/22 and reviewed on 3/4/22 revealed the lack of interventions for: *Cognitive status noted no interventions towards the goal for staff to "anticipate daily care needs" due to "advanced dementia." *Behaviors of "tendency to wander, resist cares, yell at others, and become physically aggressive" had no interventions towards the goal to have "fewer instances of anger outbursts and physical behaviors towards resident and staff." *ADL status had no interventions to address the resident's verbal and physical behaviors directed towards staff when they provided assistance due to impaired mobility and cognition. Refer to F689, finding 1. *Fall risk related to "impaired cognition" had no interventions towards the goal to be free from falls. *Mood state had no interventions to "maintain" the current level of "moderate depression." *Activity involvement did not include interventions based on her customary routines and preferences for the goal to participate in activities	F 656		

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"that bring me personal satisfaction and purpose."

Interview on 3/31/22 at 3:45 p.m. with social worker V revealed she had not written interventions on the care plan because she was still "new at doing care plans."

2. Observation and interview on 3/29/22 at 12:27 p.m. revealed resident 50 was in the fireplace lounge seated in her wheelchair with her hands grasping the armrests and trying to push herself up. After several attempts, she stopped trying. She reported she needed to go check on her family.

Comparative review of the 11/23/21 and the 2/22/22 quarterly MDS assessments revealed she had problems with vision, mood state, behavioral symptoms, and falls. Refer to F689, finding 2.

Review of the care plan started on 9/8/21 with interventions that had not been revised for problem areas including:
*Vision status to ensure the environment is safe and clutter free; "I can not always see my surroundings and often see things that are not there."
*Mood status had a goal to improve with notations that she would "cry easily...looking for her family...feels restless due to feeling she is lost and her family cannot find her."
*Behavior with a goal to decrease symptoms and interventions to "monitor hallucinations and crying episodes."
*Fall risk with a goal to prevent with interventions that included:
-Fall observations and follow-up.
-Fall risk assessments.

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F 656	Continued From page 10 -Mobility alarms "on my bed at night and in my lounge chair during the day so that staff know when I am up." -Safety measures to "put resident in [wheelchair] when she wanders with walker to prevent falls, "make sure I have nonslip footwear on at all times...fall mat is on the floor when I am in bed," and "please check me in my room for safety." Interview on 3/31/22 at 11:05 a.m. with registered nurse coordinator L confirmed the care plan had not been revised.	F 656	The care plans for resident 33 and resident 50 were updated on 4/22/22 by the RN Coordinator to include updated interventions to address resident falls and behaviors. All other residents who are at increased fall risk or who have behaviors have updated care plans with updated interventions in place. **The RN Coordinator or charge nurse will review current interventions at shift report to minimize fall and behavior risks. A checklist will be developed by 4/29/22 for shift report to include current interventions for residents at high risk of falls and/or have exhibited behaviors. (JH 4-27-22)** Education will be given to all staff at the all staff in-service on 5/10/22, 5/11/22 and 5/12/22 on the Falls and Accidents Policy and the Care Plan policy with special focus on updating new interventions following any changes in behavior or falls. The Assistant Director of Nursing will conduct audits 2 times weekly for 8 weeks to ensure new interventions are in place for residents with changing health conditions. The Assistant Director of Nursing will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the provider failed to implement interventions to provide adequate supervision based on an evaluation of risks for: *One of two sampled residents (33) for unsafe wandering. *One of four sampled residents (40) for falls. Findings include: 1. Observation and interview on 3/30/22 at 11:07 a.m. revealed: *Resident 33 moved her wheelchair	F 689		5-13-22

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F 689	Continued From page 11	F 689		

self-propelling away from the fireplace lounge and headed towards the meal service area.
*Certified nursing assistant (CNA) S approached resident 33 from the side, did not get the resident's attention, took hold of the handles on the back of the wheelchair, and tried to turn her wheelchair away from the serving area.
*The resident swung her left hand back towards CNA S and said, "She grabbed my arm."
*CNA S had deflected the resident's swing and while standing to her side said loudly to resident 33, "Listen," and told resident 33 she could not go into the serving area.
*She pushed the resident into the dining area.
*When the surveyor asked CNA S to explain her interaction with resident 33, she told the surveyor the resident had dementia, "tried to go in there," she "gets physical," had good eyesight and hearing, and she "doesn't stay" when she was directed to where she should be.

Interview on 3/30/22 at 11:33 a.m. with CNA W and registered nurse (RN) M revealed resident 33 does get physical, wanders a lot, and sometimes goes into other residents' rooms, she was "getting better" since her admission, but it was best to "approach [resident 33] from the front to get her attention first.

Review of the 2/1/22 admission minimum data set (MDS) assessment of resident 33 revealed:
*Her admission date was 1/25/22.
*She had difficulty hearing and needed people to face her when speaking.
*She was able to state her basic needs and responded to simple and direct questions from others.
*She was rarely or never able to make decisions, was not able to maintain attention, and had

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F 689	Continued From page 12 rambling or incoherent thoughts. *The mental status interview was not completed with the resident because she could not provide understandable responses. *She completed the mood interview with a determination of moderate depression. *She completed the preferences interview and stated it was "very important" to choose what to wear and what time to go to bed, to take care of her personal belongings, to have snacks available between mealtimes, to have access to reading materials, to listen to music, and be around animals. *Her behavior symptoms included having false beliefs and physical and verbal behaviors directed towards others that interfered with care, participation in activities and social interactions, and disrupted the care and living environment. *Wandering did not occur. *She needed weight-bearing support from one person for the activities of daily living (ADLs) tasks of bed mobility, transferring between surfaces, and using the toilet. Review of the Care Area Assessment documentatiion for resident 33 s revealed the lack of additional assessment for identified problem areas triggered from the answers coded on the 2/1/22 admission MDS. Refer to F636, finding 1. Review of the care plan documentation for resident 33 started on 1/26/22 and reviewed on 3/4/22 revealed the lack of interventions for cognitive status, fall risk, elopement, behavior, and mood state. Refer to F656, finding 1. Review of the behavior/mood observations documented for resident 33 during the 57 days	F 689		

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F 689	Continued From page 13 between 2/2/22 (the first date for this documentation) and 3/30/22 revealed 62 entries of behavior or mood concerns, including: *16 morning entries with the earliest time at 5:22 a.m. and the latest at 11:10 a.m. *46 afternoon and evening entries between 12:31 p.m. and 10:13 p.m. *Verbal and physical aggression towards staff was noted 54 times. *Wandering was noted 24 times, with 8 entries of her in other residents' rooms and 3 entries of physical aggression to other residents. *"What was happening before the behavior occurred" was answered only 8 times. *"Interventions attempted" was answered 25 times that included leaving her in a safe setting, "1 on 1" interaction or activity with her, or redirection or re-approaching her. Review of the 122 behavior/mood assessments completed two times on most days between 1/26/22 and 3/30/22 revealed: *The reason for the assessment was for "review of mood/behavior." *The psychotropic medications for the "target behavior" noted: -Ativan (lorazepam, a benzodiazepine to treat anxiety) PRN (as needed) 65 times. -Melatonin (a sleep supplement) 13 times. -Lexapro (escitalopram, an antidepressant) 20 times. *"Possible side effects of medications" were noted only 7 times with "agitation - increased" recorded as the side effect. *Only 12 assessments noted the "impact of behavior," which included "interfered with care, risk of physical injury or illness to self, risk of physical injury to others." *"Behavior/mood incidents" were noted as "no	F 689		

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F 689	Continued From page 14 change" 94 times, 4 times as "worse," and 4 times as "improved." Review of documentation regarding resident 33's medication regimen revealed: *A scanned "clinical note" from a telemedicine senior care provider with the date of service on 1/25/22 with an order for lorazepam 0.5 mg (milligrams) tablet "every four hours as needed for anxiety." *The medication administration record noted lorazepam was given 15 times between 2/4/22 and 3/30/22. *Consultant registered pharmacist (RPh) F documented a "Note to Attending Physician/Prescriber" on 2/21/22 and 3/22/22 that requested a "patient specific rationale" to continue the "order for PRN lorazepam." *A "Geriatric Rounds Pharmacy Medication Reconciliation" report dated 3/18/22 revealed the active psychotropic medications included: -Lorazepam 0.5 mg tablet every 4 hours PRN for anxiety. -Melatonin 3 mg tablet at bedtime. -Escitalopram Oxalate 10 mg tablet every day. Interview on 3/31/22 at 11:05 a.m. with RN coordinator L revealed: *The provider did not have a behavior/mood committee to evaluate the effectiveness of interventions for residents with those concerns. *Agreed CNA S should not have moved resident 33 in the manner that she did. *Documentation on the behavior/mood observations and assessments were not as specific as they should be to determine possible cause of behaviors. *The use of lorazepam for "anxiety" did not give a specific indication of when to use it.	F 689		

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*She had reinforced during shift huddles that resident to resident aggression had to be reported.
*The social worker is responsible for the behavior care plan.
*CNAs have discovered that resident 33 would spend time coloring.
*They were not given ideas for activity interventions from the activities department but thought it would be good to have suggestions for residents when they need to redirect from behavior or mood symptoms.

Interview on 3/31/22 at 3:45 p.m. with social worker V revealed:
*It was "hard to determine what was causing her behaviors" since the documentation was not complete in that regard.
*She agreed resident 33 needed to be approached from the front.
*She had not written interventions on the care plan because she was still "new at doing care plans." *She wondered what could be done to deter her from going into other's rooms.
*She agreed the use of Ativan was not desired.

Interview on 3/31/22 at 4:25 p.m. with consultant RPh F confirmed she had requested physician rationale for continued use of the lorazepam but had not yet received a response.

Interview on 3/31/22 at 5:15 p.m. with RN coordinator L revealed the physician discontinued the order for lorazepam.

Review of the provider's policy, "Falls and Accidents," last revised on 11/2021, revealed:
*The policy was to "provide a systematic approach to fall and accident prevention and

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F 689	Continued From page 16 monitoring, including identifying and evaluating hazards and risk, individualizing approaches to reduce the risk for falls and accidents, and monitoring for effectiveness of interventions when necessary." *Implementation of the policy included: -Staff education "about the facility's systems approach, which evaluates and analyzes hazards and risks for each individual resident based on the individual's unique status." -Assessment of "each resident's individual risk factors" and implementation of "appropriate individualized, resident-centered interventions" that is communicated to staff "through the plan of care." -Monitoring "on a regular basis" the "effectiveness and modification of interventions" through QAPI (quality assurance and performance improvement). -Hazards included "resident to resident altercations" that would be "investigated, and the facility will identify residents who are at risk to cause an altercation and address underlying reasons for their behavior." 2. Observation and interview on 3/29/22 at 12:27 p.m. revealed resident 50 was in the fireplace lounge seated in her wheelchair with her hands grasping the armrests and trying to push herself up. After several attempts, she stopped trying. She reported she needed to go check on her family. Comparative review of the 11/23/21 and the 2/22/22 quarterly MDS assessments revealed: *She had minimal difficulty hearing on 11/23/21 and moderate difficulty hearing on 2/22/22. *Her vision was highly impaired on 11/23/21 and moderately impaired on 2/22/22	F 689		

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F 689	Continued From page 17 *The mental status interview resulted in severely impaired cognition. *She was coded the delirium symptoms of inattention and disorganized thinking. *She had hallucinations and delusions without behavioral symptoms on 11/23/21 but had verbal and physical behaviors that interfered with care and participation in activities and social interactions on 2/22/22. *The interview to identify her preferences was not completed, but staff coded her "very important" choices included having snacks available between mealtimes, listening to music, being around animals, doing things with groups of people, participating in favorite activities and religious practices, and spending time outdoors. *She needed weight-bearing support from one person for the ADLs of bed mobility, transferring between surfaces, and using the toilet. *Her fall history included 2 without injury and 1 with a minor injury on 11/31/21 and 2 without injury on 2/22/22. *Bed and chair alarms were coded as used daily. Review of resident 50's care plan for fall risk dated 9/8/21 revealed the lack of revised interventions to address the risk of ongoing falls. Refer to F656, finding 2. Review of the "mobility alarm" assessments revealed all three sections (motion sensor alarm, chair alarm, and bed alarm) were answered "Yes" most of the time that the alarms were in place, working, and "compliant with alarm." On 3/11/22, all sections were answered "No." Review of the "Fall Follow Up" documentation revealed five unwitnessed falls and one witnessed fall with post-fall interventions:	F 689		

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*On 10/17/21 at 1055 a.m., the resident was found on the floor by the fireplace lying on her right side with eyes closed. She said, "I guess I just wanted to rest on the floor." Interventions included "Nothing to add to [the] care plan, we already have her in a room close to the nurses station, sensory pad in recliner and bed and fall mat beside her bed. Just need to continue to close monitoring of what she is doing."
*On 10/17/21 at 1:55 p.m., resident was found on the floor by the fireplace "lying peacefully on her left side" beside her wheelchair. She "stated that she was trying to take a nap." Similar interventions were noted.
*On 12/26/21 at 7:00 a.m., found lying on her left side on the floor beside her wheelchair near the fireplace and she said she was "trying to take a nap." Interventions were noted the same as previously.
*On 1/31/22 at 2:30 p.m., "during routine safety check...resident noted on the floor of her room...laying on her right side, head towards the door, bilateral legs crossed." Intervention noted to "continue frequent safety checks."
*On 2/2/22 at 5 minutes after midnight, the CNA found the resident with her "legs hanging off the bed" Upon trying to assist the resident to stand with her walker, the resident's "feet were too far forward so she assisted the resident to the floor." Interventions noted as "already has sensor pad in bed and recliner, low bed, fall mat, q1h [every 1 hour] safety checks."
*On 3/8/22 at 6:20 p.m., found resident "laying on her right side in her room on the floor in front of her wheelchair...stated she got up to get dressed." Interventions noted were "room checks."

Review of 8 "Fall Risk Assessments" between

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F 689	Continued From page 19 10/17/21 and 3/8/22 revealed: *Risk factors were noted as: -Altered mental status 6 times. -Impaired mobility on all. -Altered elimination [bowel and bladder incontinence] 6 times. -Taking "at risk medications" 7 times. *Interventions were noted as: -Bed/chair/mobility alarms 6 times. -"Non skid footwear" 6 times. -"Room close to station" on all. -Assess pain 4 times. -Out of bed with assistance 4 times. -"Assistive device" and "reinforce safety" 1 time. *The education component was "reason for fall risk" on all. *The recipient of the education was the "patient" 5 times and "facility staff" 2 times. *The patient's "readiness to learn" was noted as cognitively unable or not ready. Interview on 3/31/22 at 11:05 a.m. with RN coordinator L revealed: *It is not beneficial to educate the resident about her fall risk. *Confirmed the need for more specific components for the education of staff. *The previous documentation system asked about staff contact with the resident before the fall such as when the resident was last positioned or toileted but the new system does not. *She reported it would be beneficial to know that information.	F 689		
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 -	F 812		

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F 812	Continued From page 20 §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: Surveyor: 45683 Based on observation, interview, and policy review, the provider failed to ensure appropriate hand hygiene during three of three meal services by two of two servers (A and K) and one of one certified nursing assistant (CNA) (H). Findings include: 1. Observation on 3/29/22 from 11:25 a.m. to 12:04 p.m. revealed: *Server A wore gloves and took food temperatures and recorded them in the logbook. She: -Removed her gloves and had not washed her hands before putting on new gloves. -Grabbed bowls with her thumb over the rim and filled them with fruit. -Wore the same gloves as she wiped off the laminated menu sheet and removed her gloves. -Put on new gloves without washing her hands.	F 812	The staff identified for deficient practice were given individual instruction by the Support Services Manager and the Director of Nursing on 4/20/22 and 4/22/22 on proper glove use while serving resident meals. All other staff will be given education on the Standard Precautions Policy and Hand Hygiene policy in regards to glove use at the all staff in-service on 5/10/22, 5/11/22 and 5/12/22. Special focus will be given on appropriate hand hygiene while wearing gloves and hand hygiene in between glove use. The Support Services Manager will conduct audits 3 times weekly for 8 weeks to ensure appropriate hand hygiene/glove use. 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.	5-13-22

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-Served lunch from the steam table to the residents in the dining room with the same gloves on.
-Removed her gloves after serving the meal and did not wash her hands or use hand sanitizer.

2. Observation on 3/29/22 at 12:08 p.m. revealed CNA H:
*Went to the steam table and put beverages for a resident on a tray.
*Delivered the beverages to the resident's table.
*Took the tray back to the steam table.
*Went back to the table to assist the resident with eating.
*Picked up the fork and assisted the resident with her meal without washing her hands or using hand sanitizer.

3. Observation on 3/30/22 at 7:27 a.m. revealed:
*Server K wore gloves in the rehabilitation unit kitchen area. She:
-Used a disinfectant wipe to clean a tray.
-Picked up a bowl with her thumb over the rim of the bowl.
-Scooped oatmeal into the bowl and placed it on a tray.
-Removed two pieces of bread from the bag with her gloved hand and put them in the toaster.
-Opened the cupboard door and removed a plate.
-Put the plate on a tray.
-Removed the two pieces of toast from the toaster and put them on the plate with the same gloves on.
-Used a knife to butter the toast.
-Picked up a glass by the rim and filled it with orange juice.
-Put the glass on the tray and delivered it to a resident.
-Removed her gloves but did not wash her hands

F 812 Continued From page 22 F 812

or use hand sanitizer.

4. Observation on 3/30/22 at 8:20 a.m. revealed:
*Server A was serving breakfast wearing gloves. She:
-Pushed the serving cart to the table.
-Grabbed a plate with her thumb over the edge of the plate and served it to a resident.
-Pushed the cart back to the serving area.
-Grabbed another plate with her thumb over the rim of the plate.
-Used tongs to put a waffle on the plate.
-Pealed back the lids of two syrup containers with the same gloves on.
-Poured the syrup on the waffles.
-Put the plate on the cart and delivered it to another resident.
-Never did change her gloves or wash her hands.

Interview on 3/31/22 at 1:04 p.m. with support services manager U revealed she:
-Expected staff to use serving utensils instead of gloves for serving meals.
-Expected if staff used gloves, it would be for single use only and they would not touch anything else.
-Agreed if gloves were used, staff should have been washing their hands after removing them and between glove use.

Interview on 3/31/22 at 1:35 p.m. with director of nursing R revealed he expected nursing staff to wash their hands or use hand sanitizer before assisting residents with their meals.

Review of the provider's 10/21 revised hand hygiene policy revealed:
"Hand hygiene, either with soap and water or with alcohol based hand rub (ABHR):

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F 812	Continued From page 23 1. immediately before touching a resident 2. before a clean procedure or handling an invasive medical device 3. after contact with potential for bodily fluid or contaminated surfaces 4. after touching a resident or the resident's immediate environment 5. after removing gloves" Review of the provider's 6/21 effective store, prepare, distribute and serve food under sanitary conditions policy revealed: "3. Observe that employees are educated effectively to wash their hands prior to preparing, serving and distributing food. Food is covered to maintain temperature and protect from other contaminants when transporting meals to residents."	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. §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,	F 880		

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(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 880	Continued From page 24 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 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.	F 880	Corrective Action: 1. 1. For the identification lack of: *Appropriate hand hygiene and glove uses during medication administration, wound assessment, and point of care blood sugar. 2. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 5/12/22 by the Administrator, Director of Nursing or Infection Control Supervisor.	4-27-22

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 ______	03/31/2022

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**

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F 880	Continued From page 25 §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: Surveyor: 45383 Based on observation, interview, and policy review the provider failed to ensure: *One of one registered nurse (RN) Q completed appropriate hand hygiene during medication administration. *One of one certified nursing assistant (CNA) X completed appropriate hand hygiene when performing point of care testing on one of one observation. Findings include: Observation on 03/31/22 at 12:32 p.m. with RN Q administering medication revealed he: *Had been wearing gloves while he prepared insulin for administration. *He administered the insulin and removed his gloves. -Did not perform hand hygiene. *Entered another resident's room. -Did not perform hand hygiene. *Removed the resident's sock on her left foot. *Assessed a wound on her left second toe, with his ungloved hands: --Applied Iodine to the wound on her left second toe. --Helped resident with putting on her sock and a shoe onto her left foot. *He preformed hand hygiene upon exiting the resident's room.	F 880	Identification of Others: 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate hand hygiene and glove use during medication, administration, wound assessment, and point of care blood sugar. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 5/12/22 by the Administrator, Director of Nursing or Infection Control Supervisor. **Nursing staff were educated on the standard precautions policy and appropriate hand hygiene during daily staff huddles on 4/18, 4/19, 4/20, and 4/21. (JH 4-27-22)**	

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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**

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F 880	Continued From page 26 Interview on 03/31/22 at 1:30 p.m. with RN Q regarding hand hygiene he: *Had thought he used hand sanitizer more times then he had. *Agreed that he did not perform hand hygiene between glove changes and upon entering and exiting a room. *Had not worn gloves while assessing a wound and provided care. Observation on 03/30/22 at 11:18 a.m. of CNA X performing a point of care blood sugar revealed: *She did not wear gloves while performing this procedure. *She did not perform hand hygiene after exiting the resident's room. *She assisted a resident to the table. *She assisted another resident without performing hand hygiene between tasks. *Handled blood-contaminated cotton ball and lancet without wearing gloves to discard items. Interview with CNA X following procedure revealed: *She normally performed blood sugars this way. *Had been a long time since her training and could not remember if glove use was taught. *Stated she should have worn gloves since there was a risk of potential blood exposure. Interview on 3/31/22 at 9:30 a.m. with RN coordinator L regarding above observations revealed: *Staff had been educated on when hand hygiene is to be performed. *Training for staff performing point of care testing included proper use of personal protective equipment.	F 880	3. System Changes: Root Cause analysis conducted on proper hand hygiene and answered the 5 Whys. We learned through our root cause analysis that staff needed to slow down, complete tasks correctly and focus on the task at hand. 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 4-29-22. Discussion topics will include our root cause analysis, plan of correction and monitoring/audit plan.	

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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**

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F 880	Continued From page 27 Review of provider's Hand Hygiene Policy dated 4/2021 revealed: *Hand hygiene and alcohol hand rub would be used: -If hands are not visibly soiled. -Before each resident contact. -After routine resident care. -After glove removal. -Before touching clean supplies. -Prior to preparing/dispensing medications.	F 880	Monitoring: 4. Administrator, DON, or Infection Control Supervisor will conduct auditing and monitoring for proper PPE use are being done as educated and trained. 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 use will be conducted 3 times weekly for 8 weeks by the Administrator, DON, Education Supervisor and Infection control supervisor making observations across all shifts to ensure staff compliance with appropriate PPE use. * Monitoring results will be reported by administrator, DON, 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435066	A. BUILDING ______ B. WING ______	03/31/2022

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**

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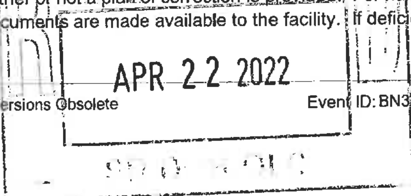
E 000	Initial Comments Surveyor: 06365 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 3/29/22 through 3/31/22. Avera Prince of Peace was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Hinker	Administrator	4-22-22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435066	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/29/2022**

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AVERA PRINCE OF PEACE	**4513 SOUTH PRINCE OF PEACE PLACE** **SIOUX FALLS, SD 57103**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/29/22. Avera Prince of Peace (building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

TITLE: Administrator

(X6) DATE: 4-22-22

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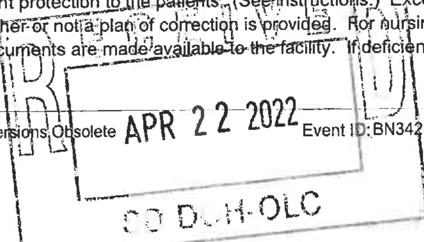

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING **02 - BUILDING 02** B. WING ______	**03/29/2022**

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AVERA PRINCE OF PEACE	**4513 SOUTH PRINCE OF PEACE PLACE** **SIOUX FALLS, SD 57103**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/29/22. Avera Prince of Peace (building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Hinker	Administrator	4-22-22

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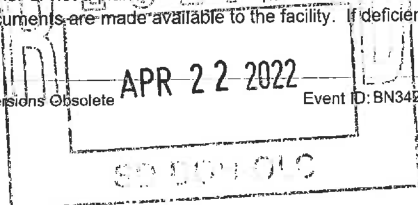

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	435066	A. BUILDING **03 - BUILDING 3** B. WING	**03/29/2022**

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**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/29/22. Avera Prince of Peace (building 03) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Hinker	Administator	4-22-22

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	10722	A. BUILDING: ____ B. WING ____	03/31/2022

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AVERA PRINCE OF PEACE	4513 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/29/22 through 3/31/22. Avera Prince of Peace was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 06365 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 3/29/22 through 3/31/22. Avera Prince of Peace was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Hinker	Administrator	4-22-22

STATE FORM 6899 NOHR11 If continuation sheet 1 of 1