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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN MITCHELL, SD 57301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/10/24 through 12/12/24. Avera Brady Health and Rehab was found not in compliance with the following requirements: F655, F684, and F760. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/10/24 through 12/12/24. Areas surveyed included potential verbal abuse by a staff member to a resident and quality of care. Avera Brady Health and Rehab was found in compliance.	F 000		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655	1) Resident 2, 26,68,69, and 71 were given copies of their baseline careplan after 48 hours. This could not be corrected due to the timeframe being in the past. A written summary of the baseline care plan will be presented to all new admissions within 48 hours of the resident's admission. Copies of the baseline care plan will be scanned into the resident's medical record. 2) Direct care nurses and interdisciplinary team were educated to ensure the resident or responsible party are given written notice of the baseline care plan within 48 hours of admission on 12/17/24 by the Director of Nursing. 3) An audit of baseline care plans will be completed by the Social Worker weekly on all new admissions for 3 months. The Social Worker or designee will bring the data to QAPI monthly for 3 months. Recommendations for further studies will be determined by the QAPI Committee.	1/8/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO/Administrator | (X6) DATE: 1/14/2025

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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§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and policy review the provider failed to review with the resident, their representative, or their responsible family member and provide a written summary of the baseline care plan for five of eighteen sampled residents (2, 26, 68, 69, and 71) within 48 hours of their admission. Findings include:

1. Review of resident 26's electronic medical record (EMR) revealed:
*She had been admitted on 7/26/24.
*Her diagnoses included acute ischemic left MCA (middle cerebral artery) stroke, with right hemiplegia (paralysis or weakness on one side of the body), aphasia (a communication disorder,

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dysphagia (difficulty swallowing), depression, anxiety, malnutrition, weakness, and a history of GI (gastrointestinal) bleed.
*Her Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated she was severely cognitively impaired.
*A care plan intervention of "I have difficulty expressing my needs so please anticipate my needs; I usually do not volunteer my needs."
*A progress note (PN) on 7/30/24 "Baseline CC [care conference] held in resident[s] room with nursing and resident. Resident was able to verbalize "fine" when asked how she was.... Current medications and POC [plan of care] reviewed and [a] copy was provided for family and resident on [the] nightstand...."
-That was completed on the fourth day of her stay.
*The provider's Plan of Care Participation Agreement was signed "unable to sign" on 7/30/24.

2. Review of resident 71's electronic medical record (EMR) revealed:
*She had been admitted on 8/23/24.
*Her diagnoses included failure to thrive, urinary tract infection with sepsis, pain, compression fracture, and a head injury.
*Her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she was cognitively intact.
*A PN on 9/16/24 "Baseline CC held in resident[s] room with resident, nursing, and ss [social services]. [C]urrent medications and POC reviewed and [a] copy [was provided] to [the] resident ..."
-That was completed on the twenty-fifth day of her stay.
*The provider's Plan of Care Participation

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Agreement was signed on 9/16/24.
*A copy of her care plan was requested but the provider was unable to provide a printed copy as the resident had been discharged.
3. Review of resident 68's EMR revealed:
*He had been admitted on 11/08/24.
*He was admitted from home due to a fall.
*He was diagnosed with right and left pelvic fractures, weakness, falls, Leukocytosis (high white blood cell count), diabetes mellitus, pulmonary hypertension, and chronic obstructive lung disease.
*His Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated he was cognitively intact.
*His baseline care plan was signed as completed on 11/11/24.
4. Review of resident 2's EMR revealed:
*She had been admitted on 10/11/24.
*Her diagnoses included congestive heart failure, pneumonia, coronary artery disease, hypertension, diabetes mellitus, and osteoarthritis.
*Her BIMS assessment score was 15 which indicated she was cognitively intact.
*Her baseline care plan had been completed on 10/13/24.
*There was no documentation of her baseline care plan being provided to her or her family.

Interview on 12/11/24 at 5:14 p.m. with director of social services (DSS) C revealed there was no documentation that resident 2's baseline care plan was discussed or provided to her. DSS C agreed that the requirement for the baseline care plan to be provided to the resident was not met for this resident.

5. Review of resident 69's EMR revealed:

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*She had been admitted on 11/14/24.
*Her diagnoses included hypertension, fibromyalgia, anxiety, and osteoarthritis.
*Her BIMS assessment score was 15 which indicated she was cognitively intact.
*Her baseline care plan had been completed on 11/14/24.
*A social services progress note on 11/18/24 that was signed by DSS C indicated her baseline care conference was held with the resident.
*A care plan participation form was signed by resident 69 and DSS C on 11/18/24.

Interview on 12/11/24 at 5:14 p.m. with DSS C regarding resident 69's baseline care plan revealed:
*Resident 69's baseline care plan was discussed and provided to the resident on 11/18/24.
*DSS C agreed the requirement for the baseline care plan to be provided to the resident was not met for this resident.

6. Interview on 12/11/24 at 5:55 p.m. with administrator A and director of nursing (DON) B regarding the requirements for baseline careplans revealed:
*The provider used their EMR's comprehensive care plan as their baseline care plan and built upon that care plan to complete the resident's comprehensive care plan.
*They agreed they had not provided all of the residents and/or family with the summary of the baseline care plan within 48 hours of admission and that there were residents that had Plan of Care Participation Agreements signed by residents after the second day of admission.
*They stated the regulation was not clear on when that baseline summary needed to be provided to the resident and family.

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Interview on 12/12/24 at 12:45 p.m. with DSS C revealed she would wait three to four days after the resident's admission before giving a copy of the baseline care plan to the resident or their family as a means to check with the resident and family to "see how things were going."

7. Review of the provider's 6/5/23 LTC (Long Term Care) Baseline/Comprehensive Care Plans policy revealed:
*"A baseline care plan will be developed within 48 hours of a resident's admission":
-"To promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission;...
-"To ensure the resident and representative, if applicable are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan."

F 684 SS=E Quality of Care
CFR(s): 483.25 F 684

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review the provider failed to maintain

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the physical, mental, and psychosocial well-being by ensuring staff promptly responded to call lights for two of eighteen sampled residents (1 and 16) who used call lights to alert staff of their assistance needs. Findings include:

1. Observation and interview on 12/10/24 at 9:51 a.m. with resident 1 in her room revealed:
*She was seated in her recliner.
*Her call light was within her reach.
*She stated it had taken staff at least 30-60 minutes go answer her call light at times.
*She said she had waited so long that she had been incontinent of bowel and bladder.

2. Observation and interview on 12/10/24 at 10:50 a.m. with resident 16 in her room revealed:
*She was seated in her recliner, with her feet elevated.
*She had a flat touch call light attached to her recliner that was within her reach.
*She needed a total body lift (a mechanical lift and sling used to lift a person's full body) to transfer between surfaces.
*She stated it could take staff "forever" to come to her room when she turned her call light on, and they "blame" that on the call light not working properly.
*She stated there had been instances when she had pushed her call light for over an hour before someone arrived.
*She pushed her call light and stated she needed to be put in her wheelchair for lunch.

3. Review of resident 1's call light audit report from 11/2/24 to 12/10/24 revealed:
*There were eighty-three call light response wait times over 10 minutes.
*There were eighteen call light response wait

F 684

1) On 12/16/24, 12/17/24, and 12/19/24 direct care nurses and CNAs participated in a root cause analysis of the call light response times. The root cause analysis was led by the DON, ADON, and Administrator. Based on the findings of the root cause analysis direct care staff were educated on the importance of anticipating the needs of hte resident. The goal of anticipating the needs is to reduce the number of call lights activated and reduce the response times of the call lights that are activated. A performance improvement team met on 1-7-25, through additional root cause analysis Resident 1's care plan was updated to assist resident to the toilet directly after meals instead of directly to the chair to prevent urgency and incontinence. Resident 1 meds were reviewed by pharmacy to determine if any medications were causing loose BMs after meals. Resident 16's care plan was updated with a toileting plan agreed upon by the resident to help alleviate anxiety around wehn staff will assist resident.
2) A QAPI performance improvement team, including members from mulitple disciplines has been established to continue efforts to reduce the number of call light occurrences and meet the needs of each resident. The first performance improvement team meeting was held on 1/7/25.
3) Data from the QAPI performacy improvement team, including call light numbers, call light response times, and resident interviews will be brought to QAPI by the DON or designee for 3 months. Recommendations for further studies will be made by the QAPI committee.

1/8/2025

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times over 20 minutes.
*There were seven call light response wait times over 30 minutes.
*On 11/26/24 at 5:37 a.m. the call light response time was 72 minutes and 39 seconds.

4. Review of resident 16's call light audit report from 11/1/24 to 12/10/24 revealed:
*There were one hundred and forty-three call light response wait times over 10 minutes.
*There were forty-four call light response wait times over 20 minutes.
*There were ten call light response wait times over 30 minutes.
*On 11/25/24 at 8:46 a.m. the wait time was 68 minutes and 56 seconds.

5. Review of resident 1's electronic medical record (EMR) revealed:
*She was admitted on 8/31/22.
*Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated cognitively intact.
*She was diagnosed with atrial fibrillation, hypertension, chronic kidney disease stage 4, osteoarthritis, hypothyroidism, and overactive bladder.
*She needed staff assistance with transfers.

6. Review of resident 16's EMR revealed:
*She was admitted on 11/20/22.
*Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated cognitively intact.
*She needed the assistance of two staff and the use of a total body lift to transfer between surfaces.

7. Interview on 12/12/24 at 8:26 a.m. with director

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F 684	Continued From page 8 of nursing B regarding call light response revealed: *The goal was for staff to respond to call lights within ten minutes 87% of the time. *All staff were responsible to answer call lights if they could. *She agreed thirty minutes is excessively long for residents to wait for assistance. *They were completing monthly audits on call lights. 8. Review of the providers Call Light Policy updated on 08/24 revealed: *"Objective: To respond to patient/resident's requests and needs on a timely basis." *"Call light scores are calculated monthly. Goal to answer call lights is within 10 minutes 87% of the time." *"If call light is defective, report immediately to maintenance."	F 684		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on Observation, interview, record review, and policy review, the provider failed to correctly administer medication for one of one sampled resident (8) by registered nurse (RN) (E) who did not verify resident had a self-administration medication order for her nebulizer treatment. Findings include: 1. Observation on 12/11/24 at 11:23 a.m. with RN E while administering medications to resident 8	F 760	1) Resident 8 was assessed for safety to self-administer a nebulizer on 12/11/24. A physician's order was obtained for resident 8 to self administer the nebulizer treatment on 12/11/24. All residents who self-administer were audited to ensure they had been assessed for safety to self administer and that the physician had ordered the self administration. 2) Nurses were educated by the DON on 12/17/24 to the policy on self administration of medications. 3)Clinical Care Coordinator or Designee will audit 2 residents weekly for 3 months to ensure that no resident is self administering medications without the self administration assessment completed and physician's order obtained. Data will be brought to QAPI committee monthly by the DON or designee for 3 months. Recommendations for further studies will be made by the QAPI committee.	1/8/25

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revealed:
*She had set up the albuterol/ipratropium (medication for breathing problems) 3 ML(milliliters) nebulizer (neb) treatment and handed the neb tube to resident 8.
*She paused the treatment because resident 8 was talking on the phone.
*Once the resident was done with her phone call, RN E started the treatment and left the room.
*RN E did not monitor resident 8 while she self-administered her neb treatment.

2. Observation and interview immediately following the above observation with RN E regarding self-administration medication orders revealed:
*If a resident had a self-administration medication order, it would appear as an intervention on their charting for the nursing staff to check off on.
*She verified resident 8 did not have a self-administration medication order on her electronic medical record (EMR).
*She verified resident 8 did not have a self-administration medication evaluation completed on her EMR.
*A self-administration medication evaluation was to be completed first on a resident then a self-administration medication order was to be obtained.
*She agreed resident 8 should not have been left unsupervised while she received her neb treatment.

3. Review of resident 8 EMR revealed:
*She was admitted on 11/27/24.
*Her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), congestive heart failure (chronic condition in

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which the heart doesn't pump blood as well as it should), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure).
*She had an order for albuterol/ipratropium 3 ML neb to be taken four times a day.
*Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated cognitively intact.
*A self-administration of medication intervention was entered into the care plan on 12/11/24 at 12:17 p.m.

4. Interview on 12/12/24 at 8:51 a.m. with director of nursing B revealed:
*Residents can only self-administer their own medications if they have a self-administration medication order.
*If residents do not have a self-administration medication order, then they must be supervised while medications are given.
*She agreed RN E should have waited and monitored the neb treatment for resident 8.

5. Interview on 12/12/24 at 9:29 a.m. with resident 8 revealed the staff would set up her neb treatments and then leave the room while she administered the neb treatments.

6. Review of the provider's updated 9/6/23 Self-Administration-of-Medications -System Standard Policy revealed:
*" ...the interdisciplinary team (IDT) will assess the resident to determine if the practice of self-administration of medications is clinically appropriate, safe, and feasible."
*"A resident may only self-administer medications after the IDT has determined which medications may be safely self-administered."

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F 760	Continued From page 11 *"C. Determination of the residents' ability to self-administer medication by the IDT will be documented in the resident's medical record and on the care plan. The documentation will also include the participation of the resident and resident representative, if applicable, in the assessment and care plan process." *"E. A physician's order will be obtained and recorded in the chart." *"G. Nurse or medication aide to check with resident each shift for appropriate medication administration."	F 760		