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 ______	C 03/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/11/24 through 3/14/24. Avera Prince of Peace was found not in compliance with the following requirements: F656 and F657 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/11/24 through 3/14/24. Areas surveyed included physical environment cleanliness, activities of daily living, call lights, and discharge planning. Avera Prince of Peace was found in compliance.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 (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).	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Hinker	Administrator	4-3-24

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.

RECEIVED APR 03 2024 SD DOH-OLC

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 ______	C 03/14/2024

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 656	Continued From page 1 (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review the provider failed to follow the pressure ulcer prevention interventions documented in the care plan for one of one sampled resident (3) who was at risk for developing pressure ulcers. Findings include: 1. Observation of resident 3 on 3/11/14 at 3:06 p.m., 3/12/24 at 1:31 p.m., and on 3/13/24 at 2:11 p.m. revealed: *She had been lying on her back in her bed. *Both heels were resting directly on the mattress	F 656	The care plan for resident identified was changed by RN Coordinator on 3/29/24 to require heel boots only at night to match current practice. Nursing staff was given education by the Director of Nursing at nursing huddles for neighborhood identified on 4/2/24 on the Care Plan Policy and importance of following care plan interventions. All other staff will be given education by the Administrator, Director of Nursing or Education Supervisor at the all staff inservices on 4/16/24, 4/17/24, and 4/18/24 on the Care Plan Policy with emphasis given on the proper use of pressure relieving devices. The Education Supervisor or designee will conduct care plan audits 3 times weekly for 8 weeks to ensure the care plan interventions are being properly followed. The Education Supervisor or designee will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	4-28-24

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 ______	C 03/14/2024

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 656	Continued From page 2 without any devices used to prevent pressure from occurring. *Her heel-lift boots were sitting on the window ledge in her room. 2. Review of resident 3's electronic medical record revealed diagnosis of stroke due to thrombosis (blood clot) of the right middle cerebral artery causing left-side weakness and controlled diabetes mellitus type two with complications. Review of resident 3's current care plan revealed she had a problem of skin integrity with an intervention "Heel lift boots on while in bed." 3. Interview on 3/13/24 at 2:12 p.m. with certified nursing assistant I regarding resident 3 revealed she: *Stated "She only lays in bed for an hour and a half only lays down in the afternoon, so we do not put them on but, we probably should." *Confirmed her care plan indicated "They should be on when in bed." *Was not aware of the resident having any history of skin issues on her heels and stated, "Which is probably why she wears the heel-lifts." Interview on 3/14/24 at 9:04 a.m. with registered nurse D regarding resident 3's heel lift boots revealed she confirmed that "Yes, her heel-lift boots should have been on whenever she was lying down per her care plan, whether it would have been twenty minutes or two hours." Interview on 3/14/24 at 12:03 p.m. with director of nursing B, regarding resident 3 revealed his expectation was that, "Whenever the resident is in bed, she should be wearing the heel-lift boots."	F 656		

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 ______	C 03/14/2024

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 656	Continued From page 3 4. Review of provider's 1/3/24 "LTC [Long Term Care] Skin Assessment/Pressure Injury Prevention-System Standard Policy revealed: *Purpose: "To provide guidelines and direction for health care professionals in ... providing care and intervention to prevent residents from the prevention of skin issues." *"Use elbow/heel protectors and multipodus boots if indicated."	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657	The care plan for residents, 9, 21, and 66 were revised on 3-21-24 and 3-29-24 by the RN Coordinator to reflect the areas identified as deficient. Education will be provided to the RN Coordinators by the Director of Nursing on 4-9-24 on the Care Plan Policy with emphasis on updating the care plan upon change in condition. All staff were given education by the Administrator, Director of Nursing or Education Supervisor at the all staff meetings on 4-16-24, 4-17-24, and 4-18-24 on the Care Plan Policy with special emphasis on notifying the RN Coordinator of residents change in condition. The Education Supervisor or designee will conduct audits 3 times weekly for 8 weeks of care plans to ensure the care plan was reviewed and revised after each assessment. The Education Supervisor or designee will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	4-28-24

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 ______	C 03/14/2024

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 657	Continued From page 4	F 657		

comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were revised to reflect the current needs of three of twenty-three sampled residents as follows:
*One of one sampled resident (9) who had three fingers amputated on her dominant hand.
*One of one sampled resident (21) who had behaviors of wandering, resistance to care, and physical altercations with other residents.
*One of one sampled resident (66) who had received hospice services.
Findings include:

1. Observation and interview on 3/11/24 at 5:41 p.m. with resident 9 revealed:
*She had a wound dressing on her right hand where three fingers had been amputated.
*She had emotional distress due to the loss of those fingers because she was dominantly right-handed.

Review of resident 9's electronic medical record (EMR) revealed she had:
*A hospital stay from 1/19/24 through 1/25/24 for cyanosis (blue discoloration) on three fingers of her right hand.
*Been evaluated in the emergency department (ED) on 1/31/24 and was hospitalized.
*Her right index, long, and ring fingers amputated.
*Returned to the transitional care unit (TCU) on 2/3/2024.

Review of resident 9's current care plan revealed it had not been revised to have:

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 ______	C 03/14/2024

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 657	Continued From page 5 *Addressed her finger amputations in her activities of daily living (ADL) area or interventions relating to the amputations. *Identified and included her emotional needs or interventions related to the loss of those fingers. *Removed a pressure ulcer to her coccyx that had healed. Interview on 3/14/24 at 9:01 a.m. with registered nurse (RN) coordinator L regarding resident 9's care plan revealed: *She updated the care plans for the residents in the TCU. *She agreed resident 9's care plan had not been revised to include her finger amputations in the ADL area or her emotional needs relating to the loss of those fingers on her dominant hand. *She stated that resident 9's care plan should have been updated to reflect that information when she returned from the hospital. *She confirmed resident 9's pressure ulcer to her coccyx had healed and remained on her care plan. *She agreed the pressure injury should have been removed when it healed. 2. Observation on 3/11/24 at 3:30 p.m. with resident 21 revealed that she was seated in her wheelchair and self-propelling herself in the hallway. After greeting her, she made eye contact and smiled but did not answer any questions. Interview on 3/14/24 at 12:18 p.m. with agency certified nursing assistant(CNA)/medication aide(MA) M regarding resident 21 revealed: *Today was her first time working with the resident. *At the beginning of the shift, the other staff stated, "I might have a little trouble with her."	F 657		

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 ______	C 03/14/2024

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 657	Continued From page 6	F 657		

*The resident was a little combative and resistive to care, she requested help from another CNA to get the resident up and dressed for the day.
*That morning, the resident refused her medications and had not eaten her breakfast because she was tired, but after a while, she reapproached the resident who then took her medications.
*When asked where she would find resident 21's care plan, she stated, "I'm not sure if it's in here [as she pointed to her laptop], but I know who to ask."

Interview on 3/14/24 at 12:27 p.m. with CNA I, who had worked the past five years at the facility, regarding resident 21 revealed she:
*Had dementia, was severely cognitively impaired, and usually did not talk.
*Wandered in and out of resident rooms daily, "taking items if they catch her eye."
*Had physical altercations with other residents in their rooms, that required staff to separate and remove the resident from the room.
*Was hard to redirect.
*Could be disruptive at times.

Review of resident 21's EMR revealed:
*She had a special indicator of being "Aggressive/Violent" that included the following statement "Clinical Staff have indicated this patient has a history of displaying aggressive/violent behavior towards themselves and/or others. Follow facility protocol for care of the patient with Aggressive/Violent behaviors."
*A 9/3/23 at 10:14 p.m. nurse progress note revealed "Several residents have complained on this night shift about [resident name] wandering into their rooms and either taking belongings or disturbing them."

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 ______	C 03/14/2024

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 657		F 657		

Continued From page 7

*A 9/14/23 at 7:01 p.m. social services progress note revealed "[Resident name] wandered into another resident's room and broke the glass to the china hutch. Staff member observed [resident name] shaking china hutch and tried to use it to stand up. Staff member caught hutch before it fell."

*A 11/29/23 at 6:46 p.m. nurse progress note revealed "Behaviors Resident has increased wandering, going in other resident's rooms, touching personal belonging, etc."

*A 2/14/24 at 7:31 p.m. nurse progress note revealed "As per [resident 28], she saw [resident 21] in [resident 33]'s room and ask her to leave the room as the light was on. [Resident 28] went in front of the TV ..., [resident 21] came after her. [Resident 21] started hitting [resident 28] in arm and squeezing her arm. [Resident 28] told her to stop hitting me and leave me alone. [Resident 28] started moving, [resident 21] grabbed her shirt ... CNA saw this and took care of situation."

*The 1/16/24 annual comprehensive Minimum Data Set (MDS) assessment revealed the following:

-Her Brief Interview for Mental Status (BIMS) was scored at zero which indicated severe cognitive impairment.

-Her physical behavior symptoms were directed toward others:

--Occurred one to three days in the past seven days.

--Significantly interfered with the resident's care.

--Placed others at significant risk for physical injury.

-Her wandering behavior:

--Occurred daily and had worsened.

--That placed the resident at significant risk of getting into a potentially dangerous situation.

--Significantly intruded on the privacy or activities

F 657 Continued From page 8 F 657

of others.
*The 1/18/24 Care Area Assessment (CAA) for her behavioral symptoms stated it was " ...triggered due to resident having physical behavioral symptoms directed towards others. Resident also wonders [wanders] throughout the neighborhood, in others room and unsafe areas. Resident has Dx [diagnosis] of dementia which contributes to these behavioral symptoms."
-She was at risk for more behavioral symptoms.

Review of resident 21's thirty-page current care plan revealed that it did not address her goals, preferences, strengths, weaknesses, or needs that were related to her wandering behavior, resistance to care, and physical altercations with others.

Interview on 3/14/24 at 12:41 p.m. with RN coordinator C revealed she:
*Was the RN coordinator for two nursing units, where resident 21 resided.
*Was not responsible for completing the resident MDS assessments or CAAs, as there were three RN coordinators who completed those.
*Reviewed the CAAs and developed or updated the resident individual care plans.
*Stated she was new to care planning as she had been in her position only a few months.
*She stated she was aware of resident 21's wandering behavior, that she could be resistant to care, and the 2/14/24 physical altercation with another resident.

Interview on 3/14/24 at 1:28 p.m. with director of nursing (DON) B revealed:
*Resident 21's special indicator "Aggressive/Violent" had been entered upon her admission on 1/24/23 that alerted staff and those

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 ______	C 03/14/2024

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 657	Continued From page 9	F 657		

providing care of her behavior problems.
*He was not aware of any facility protocol for care of the patient with Aggressive/Violent behaviors but stated there was a policy that addressed resident behaviors.
*Stated that any resident exhibiting behaviors regularly should have an intervention on their care plan addressing that behavior.

Interview on 3/14/24 at 2:47 p.m. with RN coordinator's F and E revealed:
*They both were responsible for completing resident MDS assessments and the CAAs.
*The RN coordinators on the nursing units were responsible for developing and updating the resident care plans.
-RN coordinator C was responsible for updating resident 21's care plan.
*After reviewing resident 21's 1/16/24 annual MDS, 1/18/24 CAA, and documentation in the EMR regarding her behaviors, RN coordinator F agreed that she would expect to see a behavior problem addressed on the resident's care plan:
-She stated the following from resident 21's CNA documentation which identified:
--On 2/14/24, physical aggression.
--On 2/22/24, wandering behavior.
--On 2/28/24, resistant to care with the note, resident 21 "attempted to bite my arm."

Review of the provider's 1/24/24 Special Indicators Crosswalk revealed:
*The document had an overview to "Provide education on purpose of and process for adding, editing, and removing Special Indicators" for their EMR software.
*Background: "Special Indicators are available when registering and caring for patients in all care settings and will alert the [EMR brand name] user

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 ______	C 03/14/2024

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 657	Continued From page 10 of special needs that will need to be considered while caring for them." *The document provided instructions on how to add, edit, and remove or delete an indicator. *The document listed twenty-nine special indicators including "Aggressive/Violent". -The "Aggressive/Violent" special indicator was able to be entered and/or edited by "All users" of their EMR. --"Patient has a history of displaying aggressive/violent behavior toward themselves and/or others." --"Comment summarizing reason for indicators is required." Review of the provider's March 2021 Behavioral Health policy revealed: *Purpose: "It is the policy of this facility that each resident must receive and the facility must provide the necessary behavioral health care and services ...to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." *Policy Statement: " ...This facility will provide the necessary behavioral health care and services which include ...Individualized non-pharmacological interventions will be care planned ..." *Definitions "Behavior: Behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment." *Procedure ... RAI Process: -"The RAI process (MDS, CAA's and Care Planning) will be completed by the Interdisciplinary Team to determine person-centered care plan goals and approaches	F 657		

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 ______	C 03/14/2024

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 657	Continued From page 11	F 657		

based upon the comprehensive assessment."
-"Based upon the assessment findings, the interdisciplinary team will complete a comprehensive Person-Centered Care Plan including individualized mood and behavior interventions and approaches ..."
-"Recognition and Management of Dementia:"
--"The facility will assess and determine individualized behavioral care plan interventions for individuals with dementia in order to be able to provide specialized services and supports."
--" ...Care plan goals will be developed based upon the comprehensive assessment including input from the interdisciplinary team, resident, resident's representative and/or family and achievable [sic]."

3. Observation and interview on 3/11/24 at 5:22 p.m. of resident 66 in the dining room revealed:
*She was seated in her wheelchair at the table, eating independently her pureed foods from a divided plate with a two-handled covered cup with thickened water. She responded to a greeting and replied, "It's good," when asked about her supper meal. She did not answer any other questions.

In person interview on 03/11/24 at 3:15 p.m. of resident 66's daughter-in-law revealed:
*She visited the resident once a week, another daughter-in-law visited regularly, and the resident's daughter visited more often.
*She stated the resident was on hospice care, but she had not met any of the hospice staff.

Observation on 3/12/24 at 10:22 a.m. of resident 66 in the dining room at her table alone with a clothing protector on. In front of the resident was a glass of thickened juice with a plastic spoon

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 ______	C 03/14/2024

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 657	Continued From page 12	F 657		

inserted into the glass and a mug of thickened liquids with another plastic spoon inserted into the mug. An unidentified staff member stated her divided plate had been removed with the drinks remaining on the table. Both the glass and the mug was full of thickened fluids and it appeared that none of the fluids had been consumed. The unidentified staff member did not address the resident or encourage her to drink some of the fluids.

Review of resident 66's EMR revealed:
*A scanned agreement from the hospice provider, which was signed by the resident's daughter on 1/26/24, for hospice services to begin that day.
-The agreement stated the qualifying hospice diagnosis was "Senile degeneration of brain".
*A 1/30/24 significant change comprehensive MDS assessment recorded:
-Her BIMS was scored at four, which indicated severe cognitive impairment.
-She was receiving hospice care.

Review of resident 66's current care plan revealed it did not address what the hospice was responsible for and what the nursing home was responsible for.

Interview on 3/14/24 at 2:35 p.m. with RN coordinator's F and E regarding resident 66 revealed:
*The 1/30/24 significant change in status comprehensive MDS assessment was completed related to her hospice care which started on 1/26/24.
*RN coordinator E located the hospice provider's scanned 1/26/24 "Hospice Plan of Care" in the EMR and stated that the hospice plan of care should have been integrated into her

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 ______	C 03/14/2024

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 657	Continued From page 13 comprehensive care plan. *RN coordinator F stated the hospice agency provided a "blue sheet" that identified how often the RN, CNA, and social worker would visit the resident and that should have been included in the resident's care plan. *Both agreed that the hospice plan of care and frequency of visits should have been addressed in the resident's care plan. Review of the provider's June 2023 policy on "LTC [Long Term Care] Baseline/Comprehensive Care Plans" revealed: *Policy "The interdisciplinary team will develop a ... comprehensive care plan for each resident ... to provide effective and person-centered care of the resident ..." *"The care plan will be reviewed and revised by the interdisciplinary team after each assessment."	F 657		

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 ______	03/14/2024

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
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 3/11/24 through 3/14/24. 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	4-3-24

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.

RECEIVED
APR 03 2024
SD DOH-OLC

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 01 - MAIN BUILDING 01 B. WING	03/13/2024

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/13/24. Avera Prince of Peace Building 01 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=D	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. 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)	K 321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Hinker
TITLE: Administrator
(X6) DATE: 4-3-24

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.

APR 0 3 2024
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING **01 - MAIN BUILDING 01** B. WING	03/13/2024

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
K 321	Continued From page 1 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain two separate hazardous areas (resident room B111 used for storage and resident room B112 used for storage) as required. Findings include: 1. Observation on 3/13/24 at 11:05 a.m. revealed resident room B111 in the patient wing was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer. A closer was required for a storage room greater than 100 square feet. 2. Observation on 3/13/24 at 11:10 a.m. revealed resident room B112 in the patient wing was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer. A closer was required for a storage room greater than 100 square feet. 3. Interview with the facility services manager at the times of the above observations confirmed those findings. The deficiency affected two of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321	The doors on rooms B111 and B112 had closers installed on 3-21-24 by Journey Construction. There aren't any other doors that need closers in the facility. Education was given by the Administrator, Director of Nursing or Education Supervisor on the regulation regarding storage in the facility at the all staff inservice on 4/16/24, 4/17/24 and 4/18/24. Education emphasized that any combustible storage had to have the door equipped with a closer. The Maintenance Supervisor will conduct audits weekly for 8 weeks to ensure there are no areas in the facility that have storage with no closers. The Maintenance Supervisor will report the results of the audits to the QAPI committee that meets every other month. The QAPI committee will direct further audits.	4-28-24

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

PRINTED: 03/26/2024
FORM APPROVED
OMB NO. 0938-0391

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 ______	**03/13/2024**

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/13/24. 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: Justin Hinker

TITLE: Administrator

(X6) DATE: 4-3-24

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.

RECEIVED
APR 0 3 2024
SD DOH-OLC

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

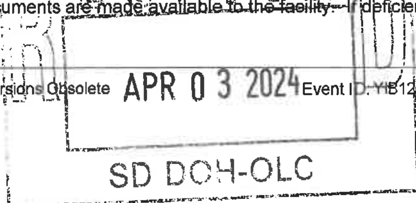
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING **03 - BUILDING 3** B. WING ____________	03/13/2024

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/13/24. 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	4-3-24

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.


RECEIVED
APR 03 2024
SD DOH-OLC

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
	10722	A. BUILDING: ___ B. WING ___	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	**4513 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/11/24 through 3/14/24. Avera Prince of Peace was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/11/24 through 3/14/24. 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	4-3-24