STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/29/25 through 10/2/25. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirements: F578, F585, F695, F725, F732, F812, and F880.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information	F0578	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Long Term Care (LTC) code status/resuscitation policy was reviewed by the IDT team during an ad hoc QAPI meeting, no changes needed. The facility's resident handbook was reviewed and updated by Administrator and updated to include a date. Resident #55 was provided with the new educational pamphlet, "Personal Choices and Issues Surrounding Health Care Decisions", and her code status was reviewed. The resident's code status was changed to "Comfort Care Only, DNR/DNI" and physician order obtained; this aligns with her advance directive. The Statement of Understanding Resuscitation Status form was updated on 10/15/25 by the RCC. All current residents' code status was reviewed by RCC and orders updated if needed. RCC reviewed any resident with an advance directive to ensure it aligns with the code status form.	01/24/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Henrickson	Administrator	12/26/2025

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F0578 SS = D	Continued from page 1 or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to protect the resident's rights and ensure a resident's advance directive code status (an individual's desire to be resuscitated with cardiopulmonary resuscitation (CPR), specific limited interventions, or not resuscitated (DNR) if their heart stopped) wishes were identified accurately on the physician's orders and the care plans for one of 32 sampled resident (55). Findings include: 1. Observation on 9/29/25 at 2:53 p.m. outside of resident 55's room revealed she had a red dot on her name plate on her door. 2. Interview and review of resident 55's electronic medical record (EMR) on 9/30/25 at 4:30 p.m., and on 10/1/25 at 4:43 p.m. with licensed practical nurse (LPN)/resident care supervisor J revealed: *Residents' code statuses (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) were ordered by their physician. *The residents did not sign code status forms. *If a resident's code status changed, the provider would request an order from the physician to change it. *She looked in resident 55's EMR and determined the resident had a full code status (life sustaining measures if one's heart or breathing stop). *If resident 55 was found not to have a heartbeat, she would perform CPR immediately. *She reviewed resident 55's 7/31/25 living will and stated that the resident's code status was supposed to	F0578	A new form was created to align with the policy, giving four options for code status. This form is reviewed by a nurse with the resident or representative on admission and changes in condition. It is reviewed quarterly at care conferences by the Social Worker (SW)/SW designee/RCC. The nurse will verify if there is a living will/advance directive and ensure all forms align on admission. Any discrepancies will be reviewed for clarity with supporting documentation. The resident's code status preference is shared with their Provider, a physician order placed and scanned into the chart. All current residents have completed their code status preference using this new form. All forms have been scanned into the chart with new orders updated if needed. The nurse leadership team met and made the decision to eliminate the use of the red dots, all were removed by 12/10/25. Clinical Staff will be educated to use the physician orders to verify code status of all residents, which will be included in the required education to clinical staff for this survey. All residents or representatives will receive an education pamphlet on Personal Choices and Issues Surrounding Health Care Decisions. This is provided on admission, as needed and provided to current residents. These pamphlets will be used for all admissions/readmissions moving forward. Professional nurses will be educated on the "LTC Code Status/Resuscitation" policy. Any nurse who does not meet the deadline for education will be removed from the schedule until completed. Audits were started the week of 10/21/25 by Resident Care Coordinators (RCCs) to ensure resident code status is completed per policy; 10 audits weekly for 6 weeks. On 12/15/25 audits were reviewed at ad hoc	

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F0578 SS = D	Continued from page 2 be DNR. *She reviewed the resident's physician's orders, and her full code order was ordered on 8/5/25, upon her admission to the nursing home. *She reviewed the resident's hospital discharge orders from 8/5/25, and those orders indicated she had a full code status. *She completed resident 55's assessments and care plan upon admission to the nursing home. *She was to verify the resident's code status wishes with the resident when the resident admitted to the nursing home. *She did not have documentation to support that resident 55's code status was reviewed with her to ensure her wishes would have been followed. 3. Interview on 10/1/25 at 8:32 a.m. with certified nursing assistant (CNA) R revealed the red dots on the residents' name plates of their door meant they had full code status. 4. Interview with resident 55 on 10/1/25 at 3:59 p.m. revealed: *No one talked to her about her code status wishes since she arrived at the nursing home. *She did not want CPR performed if her heart or breathing stopped, and she was upset that she was ordered to have CPR. *She had a living will that stated she did not want CPR, and she signed that document while in the hospital, shortly before she was admitted to the nursing home. 5. Further review of resident 55's EMR revealed: *Upon her admission on 8/5/25, she had orders from her physician for her code status to be full resuscitation, which were entered by licensed practical nurse (LPN)/resident care supervisor J. *Her 7/31/25 living will stated, "If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life-sustaining treatment has been started, stop it, but keep me comfortable and control my pain."	F0578	QAPI and moved to 10 audits every two weeks for 4 weeks. Corrective action/education will be taken if there any discrepancies by the DON or designee. Findings will be shared at ad hoc weekly and quarterly QAPI meetings for further recommendations.	

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F0578 SS = D	Continued from page 3 *Her living will declaration stated: "This is an important legal document....", and "This living will remains valid and in effect until and unless you revoke it." *Her 8/15/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *Her printed baseline care plan's first page listed her code status as full code, in smaller writing, which was signed on 8/6/25 by LPN/resident care supervisor J and resident 55. 6. Interview on 10/2/25 at 11:22 a.m. with registered nurse (RN)/quality and infection prevention supervisor B and interim director of nursing (IDON) AA revealed: *The residents' code status wishes were reviewed with the resident and/or family representative, and then they would request an order from the resident's physician that reflected the resident's code status wishes, unless their code status was listed in the resident's admission orders. *The residents did not sign code status forms. *When asked how they ensured they were following the residents' code status wishes and not just the physicians' orders if there was no document signed by the resident or the resident's representative, RN/quality and infection prevention supervisor B stated, the designated staff member was to discuss it with the residents. *IDON AA stated the admitting staff member needed to look at both the physicians' orders and the residents' advance directives upon admission to determine the resident's code status wishes were followed based on the resident's wishes. Review of the provider's 2/20/2025 Advance Care Planning Policy revealed: *" The goals of the advance directive policy are to promote human dignity and self-determination, to ensure that patients' advance directives are honored, and to ensure compliance with the Patient Self-Determination Act of 1990." *" When an advance directive document is provided to the facility...an active problem list item "Advance care planning" is created and a permanent comment is entered that states the type of document...."	F0578		

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F0578 SS = D	Continued from page 4 *" Advance care planning allows the resident to consider and express their values, goals and wishes regarding care and treatment." Review of the provider's undated Nursing Facility Admission Handbook and Resident Care Policies revealed: *During the admission process all new residents will be presented with information regarding Code-No Code. This will be explained to the resident, resident representative and all the available family members by the Social Services Department. The resident or the resident representative must sign the form designating the desired status. The family will be made aware of the fact that the physician must be in agreement with this decision before an order is written."	F0578		
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings	F0585	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The LTC Grievance/Complaint policy and the LTC Resident Bill of Rights and Responsibilities policy were reviewed by IDT and no changes necessary. Grievances and the result of the grievance will be maintained by the Social Worker for a minimum of three years. Residents 55, 76, 89, 67 and 90 were reviewed by the DON and ID RN on 12/18/25. Resident 55 was discharged on 10/16/25, she was interviewed on 10/15/25 by the SW. Dietitian was unable to follow-up on food concerns due to discharge. Resident 89 was discharged on 12/12/25, she was interviewed by the Activity Supervisor on 10/17/25, follow up was provided on 10/21/25 by DON. Resident 90 was discharged on 10/10/25, hearing aids	01/24/2026

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F0585 SS = E	Continued from page 5 in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State	F0585	were ordered on 10/13/25 and replaced by the facility. Resident 76 was interviewed on 10/13/25 by the Activity Supervisor, follow-up was provided by the Administrator per resident request on 10/20/25. This resident was interviewed again and follow-up was provided by the DON on 12/19/25. Resident 67 was interviewed on 10/17/25 by the Activity Supervisor, follow-up was provided 10/20/25 by the dietitian and again on 10/21/25 by the DON. This resident was interviewed again on 12/19/25 by the DON and follow-up was provided. All current residents at the facility were interviewed by our Social Worker, Activity Supervisor or designee and follow-up provided for all resident concerns or complaints. Residents will be interviewed by Activities, SW or designee quarterly to identify and resolve resident concerns or complaints. Any trends or patterns identified will be reviewed at QAPI for recommendations. Three new grievance boxes are now displayed at the entranceway of the building and each hallway for residents to anonymously report any complaints and/or grievances. The grievance officer's name, business address, email, contact information and the expected time frame for review completion will be displayed on the mailboxes along with complaint forms and writing tools. All residents/representative were notified of the grievance box and grievance form locations via written notification delivered by the Activities Supervisor or designee. The grievance boxes will be checked daily, Monday through Friday by the social worker or designee, follow-up will be provided as needed. Any trends or patterns identified will be reviewed at QAPI for recommendations. The social worker has developed a new excel form to track complaints, grievances and missing items. The log includes resident name, date of occurrence, complaint type and resolution. The SW or designee will be responsible for the upkeep of the log. Grievance policy is included in the admission packet and provided to all current residents/ representatives and all residents on admission. The grievance officer and	

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F0585 SS = E	Continued from page 6 Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and policy review, the provider failed to implement an effective grievance process to ensure residents' satisfaction with the resolution of voiced grievances for: *Two of two sampled residents (55 and 76) regarding long call light response times and noise at night. *One of one sampled resident (89) regarding long call light response times and receiving medications late. *One of one sampled resident (67) regarding cold food and menu choices. *One of one sampled resident (90) regarding lost hearing aides. Findings include: 1. Interview on 9/29/25 at 4:21 p.m. with resident 89 revealed: *Resident 89 stated that she felt that one nurse aide had treated her poorly. Resident 89 explained that she went to bed at approximately 8:30 p.m. one evening and, about three hours later, activated her call light to request assistance to use the bathroom. When the nurse aide responded, the aide stated, "I just took you." Resident 89 insisted on being taken to the bathroom, and the aide assisted her but commented, "I can't be coming in every five minutes." Resident 89 told another nurse aide about it the next day, whom she described as "one of my favorites," but she was not offered or asked if she wanted to file a grievance. She declined to identify that staff member. She did not report that incident to any other staff and stated, "All of the other staff are great." *Resident 89 was also concerned regarding the timing when she was given her morning nausea medication, Zofran. She stated the medication was consistently administered late in the morning, by which time she was	F0585	Ombudsman information has been added to the admission packet. The facility's resident handbook has been updated with current grievance policy and dated. The facility's grievance officer and local Ombudsman contact information was updated and posted near the main nurses station and business office. Residents will be informed of the right to make complaints or grievances at admission, readmission, care planning conferences and orally at resident council meetings. Any concerns or complaints at resident council meetings will be brought the appropriate leader to address with the resident. This process is monitored and tracked by the Activity Supervisor. A new leadership meeting agenda form was created to include social services or designee to include updates on complaints, grievances and missing items and resolution. Staff will be educated on these policies (The LTC Grievance/Complaint policy and the LTC Resident Bill of Rights and Responsibilities) and AIDET (customer service tool). Staff who don't meet the deadline for education will be removed from the schedule until completed. Additional education was provided to the Social Worker designee, Activities Supervisor and the Nurse Leadership Team on the grievance process per policy and on the location of the grievance material in the facility. The SW/SSD and the Activity Supervisor were educated by the DON and/or ID RN on how to use the electronic medical record (EMR) Risk management system. Audits of grievances were started the week of 10/21/25 by the SW/SSD/AS to ensure that resident concerns are acknowledged, tracked and addressed in a timely manner. Five audits will be conducted every two weeks for six weeks and monitored for compliance by DON or designee. Corrective action/education will be provided as needed. Findings will be shared at ad hoc weekly and quarterly QAPI meetings for further recommendations.	

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F0585 SS = E	Continued from page 7 already experiencing nausea and was unable to eat several noon meals as a result. Resident 89 tried to be more insistent to staff about receiving her Zofran earlier, but there was no change to the time the medication was administered. 2. Interview on 9/30/25 at 9:06 a.m. with resident 55 in her room revealed: *She had experienced urine incontinence episodes when waiting long times for staff to respond to her call light. She unsafely took herself to the bathroom, at times, when she felt she had to wait too long for staff to respond to her call light. *She felt staff were loud at night, laughing and joking in the hallway, and her roommate yelled out her name at times, which kept her awake. *She notified the previous director of nursing and registered nurse (RN)/quality and infection prevention supervisor B about long wait times for staff response to her call light and needing to take herself to the bathroom, loud staff and roommate at night, but it was still happening.3. Interview on 9/29/25 at 4:28 p.m. and 10/1/25 at 3:35 p.m. with resident 76 in her room revealed: *She had to wait a while for the staff to answer her call light, especially in the morning. *The resident across the hall hollers and bangs at night, keeping her awake. *She complained to a staff member about the long call light times and the resident across the hall being loud at night, but she was unsure who she told, and it continued to happen. *She was unsure how to file a grievance. 3. Interview on 9/29/25 at 4:32 p.m. with resident 67 revealed she: *Preferred to eat her meals in her room. *Stated her food was often cold when she received it in her room. *Told the kitchen staff that her food was often cold, but no one had followed up with her regarding that concern, and her food continued to be delivered to her cold.	F0585		

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F0585 SS = E	Continued from page 8 Observation and interview on 9/30/25 at 9:03 a.m. with resident 67 in her room revealed she: *Had her breakfast tray on her over-the-bed table. *Was only given water to drink, and she reported she preferred to have milk with her meals. *Did not fill out her menu choice and she was not sure who had. Interview on 10/2/25 at 8:40 a.m. with resident 67 revealed she: *Had not filed a grievance. *Did not know how to file a grievance. *Did not remember being told she could file a grievance or what the process was to file a grievance. 4. Interview on 9/29/25 at 5:21 p.m. with resident 90 revealed she stated that her hearing aid was lost, which she believed occurred "yesterday." She reported that staff had looked in her trash and in her recliner for the hearing aide. The resident stated she was not aware of how to file a grievance and had not been offered assistance by anyone to do so. She also reported she was unsure what actions, if any, the facility was taking regarding her lost hearing aid. 5. Interview on 10/1/25 at 8:32 a.m. with certified nursing assistant (CNA) R revealed: *Residents complained about the staff being loud a few months ago, and management talked to the staff about it. *Resident 76 complained to her about the resident across the hall from her (resident 30) being loud at night. 6. Interview on 10/1/25 at 2:45 p.m. with business office coordinator I revealed: *There had been a recent change within the social worker position. *For 2025, the only grievance logs the provider had been from 1/1/25 through 3/31/25. 7. Interview on 10/2/25 at 7:30 a.m. with CNA EE who worked the night shift revealed:	F0585		

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F0585 SS = E	Continued from page 9 *Resident 30 was loud and would wake up the other residents at night. -She told registered nurse (RN)/quality and infection prevention supervisor B about resident 30 being loud about a week ago, and was told RN/quality and infection prevention supervisor B would get the social worker and licensed practical nurse (LPN)/resident care supervisor J involved. She was unsure if anything had been done about it yet. *Some CNAs were loud at night, and they were told to be quieter by management. She had not heard anything else about that. 8. Interview on 10/2/25 at 8:05 a.m. with CNA Q revealed: *If a resident had a complaint, she would tell the nurse and try to find out the source of the problem. *She did not know how to help the resident file a grievance. *Resident 55 told her about the staff and her roommate being loud at night. CNA Q did not tell anyone about the resident's concerns because she thought the nurses already knew about it. *Resident 30 banged his call light on the bedside table at times. A management staff person talked to him to let him know he was disturbing others, and that behavior decreased for a little while, but he was doing it again. 9. Interview on 10/2/25 at 8:20 a.m. with social worker (SW) G revealed: *If a resident had a complaint, there was a form they could fill out, and she would then review it and log it in the grievance book. -No one had filled out a grievance form that she knew of since she had started at the nursing home. *If a resident told a CNA about a complaint, the CNA should report it to the department that the complaint was about. *If a resident told a nurse about a complaint, the nurse should tell the director of nursing or the administrator. *Morning staff meetings were held to discuss facility	F0585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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

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F0585 SS = E	Continued from page 10 happenings (ie. falls and complaints). -She heard in the morning meeting that a resident had yelled and banged on things at night, but she only heard about that once. -She stated that concern was addressed with the resident who was loud and with the residents who complained about it about a month ago, on one of her first days of working at the nursing home. -She was not aware that resident 30's disruptive behavior continued to be an issue. *Resident 55 reported to her that she had not received good personal hygiene care provided by a night CNA. -Administrator A talked to that CNA and resident 55 and SW G thought that resolved the issue. *She did not have any documentation of the resident's grievances being followed up on by other staff. She would document in the resident's chart regarding grievances she followed up on. *She received residents' complaints regarding long call light times a few times, and she talked to that resident. The resident care coordinator, for that resident, was to run a call light report and then talk to the nursing staff regarding long call light wait times. *Complaints brought forward by the resident council were to be brought to the leaders of the department the complaints were about. *If a complaint was received during a care conference, she would notify the leader of the department the complaint was about, so the department lead could follow up with that concern. She documented in the residents when she followed up on grievances. *She was unsure if the morning staff meetings were documented to indicate if residents' grievances or concerns were discussed. 10. Interview on 10/2/25 at 8:38 a.m. with LPN FF revealed: *If a CNA or resident told her a complaint, she would try to solve it, and if she was unable to solve it, she would tell her supervisor. *She was not sure how to file a grievance for a	F0585		

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F0585 SS = E	Continued from page 11 resident. 11. Interview on 10/2/25 at 8:40 a.m. with resident 67 revealed she: *Had not filed a grievance. *Did not know how to file a grievance. *Did not remember being told she could file a grievance or what the process was to file a grievance. 12. Interview on 10/2/25 at 8:54 a.m. with certified nursing assistant (CNA) P revealed: *She had not filed a grievance for a resident. *If a resident had a concern, she would notify her supervisor or the nurse on duty about the resident's concern. *She thought the grievance form was available online and was to be completed if she had an issue with a coworker. *She did not know who the provider's grievance officer was. 13. Interview on 10/2/25 at 9:07 a.m. with registered nurse (RN) E revealed: *She had worked at the facility for three months. *She had not filed a grievance for a resident or a resident representative. *If a resident brought a concern to her attention, she would attempt to address that concern immediately. If she was unable to resolve the resident's concern, she would either email or tell the manager responsible for that area what the grievance was about and who reported it to her. *There were grievance forms available in a drawer at the nurses' station and at the front desk. *If a resident asked to file a grievance, she would assist that resident if needed. *She was not aware of any grievance forms that were available for anyone without asking a staff member for the grievance form. *She did not know who the provider's grievance officer	F0585		

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F0585 SS = E	Continued from page 12 was. 14. Interview on 10/2/25 at 9:12 a.m. with social worker G revealed: *She was the grievance officer for the facility. *The process to file a grievance was gone over with the resident or the resident representative on admission and was in the resident 's admission packet. *She was not aware of any material posted in the facility related to the facility's grievance process. *She did not know if there were any grievance forms available for residents or family members to complete without asking a staff member for the form. 15. Interview on 10/2/25 at 10:55 a.m. with administrator A revealed: *She would try to handle a complaint as soon as it was received. *Social worker G handled the grievances, had the grievance forms, and kept copies of all the grievances in a book for two years. *A grievance would be any complaint that was not resolved with the resident and/or family. -They only had four documented grievances in the past year. *She expected complaints brought up in resident care conferences and their resolution to be documented in the resident's electronic medical record (EMR). *If a resident reported a complaint to a CNA, she expected the CNA to tell the nurse supervisor. *She expected the resident care coordinators to address resident complaints, and if they were not able to resolve them, then they should notify her. 16. Review of the provider's September 2024 Grievance/Complaint- System Standard policy revealed: *"It is the policy of this facility that each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination of reprisal. Such grievances include	F0585		

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F0585 SS = E	Continued from page 13 those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding the LTC [long term care] facility stay." *"The facility grievance process will be overseen by a designated Grievance Official who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining the confidentiality of all information associated with grievances, communicate with residents throughout the process to resolution and coordinate with other staff". *"The facility will provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service; will provide residents, resident representatives and others information about the mechanisms and procedure to file a grievance; provide a designated individual to oversee the grievance process; provide a planned, systematic mechanism for receiving and promptly acting upon issues expressed by residents and resident representatives and will provide and ongoing system for monitoring and trending grievances and complaints." *"The facility will inform residents orally and in writing of their right to make Complaints and Grievances and the process to do so during admission, readmission and the care planning process. The notice shall include: -a. Information on how to file a grievance or complaint -b. Resident right to file grievances orally or in writing -c. Resident right to file grievance anonymously -d. Contact information of the facility designated Grievance Official -e. Reasonable time frame for completing the review of a complaint -f. Resident right to obtain a written decision regarding his or her grievance -g. Contact information of independent entities with who grievances may be filed in each of the various states [the corporation] facility operates in. -h. Additional notices of the facility grievance process will be displayed in prominent locations	F0585		

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F0585 SS = E	Continued from page 14 throughout the facility (Front entrance and Administration)." *"A grievance or concern can be expressed orally to the Grievance Official, facility staff or in writing using a grievance form." *"Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official". *"The grievance Officer will maintain a log of all grievances and/or entered into EMR Risk Management Reporting System for a period of 3 [three] years including; -1. Date of the Grievance -2. Tracking number or identification -3. Type of Grievance -4. Location/Department -5. Person assigned to investigate -6. Date response letter sent -7. Comments/Actions". *"The facility will track, trend and analyze the grievance process and findings for trends, performance gaps and opportunities for individual education, system and systemic improvement. The facility will incorporate the Grievance/Complaints into the Quality Assurance and Performance Improvement program."	F0585		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F0695	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Avera LTC-Respiratory Equipment policy was reviewed by IDT team; no	01/16/2026

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F0695 SS = D	Continued from page 15 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed respiratory professional standards for: *The clean storage of nasal cannulas (flexible tubing with prongs that delivers oxygen through the nose) for three of three sampled residents (5, 50, and 90) who used them. *The cleaning and storage of nebulizer masks (a mask worn when using a nebulizer machine that converts liquid medication into an inhalable mist) for three of three observed sampled residents (5, 42, and 63) who used them. *The cleaning of Continuous Positive Airway Pressure (CPAP) machines (a device that uses air pressure to keep breathing airways open) for two of two observed sampled resident (5 and 90) who had CPAP machines in their rooms. Findings include: 1. Observation and interview on 9/29/25 at 4:05 p.m. with resident 63 revealed that she was seated in a recliner in her room. Her right hand was contracted, and she was unable to move the fingers of her left hand. A nebulizer machine was on the bedside table, with liquid in the medicine chamber, approximately three-fourths full. Resident 63 stated that nursing staff assisted her with the nebulizer treatments, as she was unable to physically operate the machine independently. The nebulizer had liquid remaining in it, which indicated the nebulizer was not disassembled, cleaned, and left to air dry prior to reassembling it. Review of resident 63's electronic medical record (EMR) revealed she was admitted on 5/8/23. Her 7/31/25 Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. 2. Observation on 9/29/25 at 2:37 p.m., of resident 90's room was revealed the resident was not in the room. An oxygen concentrator (a device that filters room air into purified oxygen) was on and set at two liters (L) per minute. The tubing and nasal cannula was draped over the top of the concentrator. A CPAP machine was on the bedside table. The CPAP machine had a reservoir that was approximately three-fourths full of a clear liquid that appeared to be water. Condensation was visible on the top half of the reservoir.	F0695	changes needed. On 10/14/25, residents 5, 50, 90, 42 and 63 were reviewed by DON, ID RN and Medication Aide, who was tasked with conducting audits. All issues noted in the 2567 were resolved by 10/16/25 by our Medication Aide who has been tasked with ensuring our policy is being followed regarding routine cleaning and maintaining respiratory equipment. Resident #63's nebulizer mask and machine was cleaned per policy. Resident #90 was discharged on 10/10/25; her tubing and nasal cannula were exchanged and stored properly when not in use. The CPAP machine was also cleaned per policy. The concentrator turned off when she was not in the room. Resident #50's concentrator is being turned off when he is not in the room. His oxygen tubing was exchanged and is now being stored properly. Resident #5's nebulizer mask and machine was cleaned per policy. Her CPAP machine was cleaned per policy and is now being stored appropriately. Her nasal cannula was also replaced and being stored per policy. Resident #42's nebulizer machine was cleaned and stored per policy. On 10/16/2025, all residents at the facility were reviewed by the ID RN and DON, those identified with respiratory equipment needs (oxygen concentrators, nebulizers, CPAP and BIPAP machines etc.) were audited to ensure policy is being followed and any corrective action taken by our Medication Aide, overseen by the DON. Professional nurses and medication aides were educated on this policy. Any nurse or medication aide who does not meet the education deadline will be removed from the schedule until completion. One on one education was provided to the medication aide responsible for cleaning respiratory equipment by the DON which included a review of the Respiratory Equipment policy, review of manufacturer's instructions on respiratory equipment and the auditing process on the respiratory equipment. Audits were conducted starting the week of 10/21/25 and ten audits per week were conducted by the assigned medication aide to ensure the respiratory equipment is maintained per policy. Findings were shared	

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F0695 SS = D	Continued from page 16 3. Observation and interview on 9/29/25 at 5:21 p.m. with resident 90 revealed: *She did not use her CPAP machine because she used oxygen at night instead. *A CPAP machine was on her bedside table. The water reservoir was about three-fourths full of clear liquid, with condensation on the top half. The tubing had a blue connector that allowed oxygen to be added to the CPAP. *Resident 90 said she was unaware that the machine could be used with oxygen. The oxygen concentrator flow rate was set at two liters and turned on, with the tubing and nasal cannula draped over the top. The improper storage of the nasal cannula posed a risk of contamination, which then would have been transferred into resident 90's nasal passage when it was placed in her nose. Resident 90 stated that the concentrator was always left on, even when she was not using it. She said she had asked the staff to turn it off, but they told her it needed to always remain on. Review of resident 90's EMR revealed her admission date was 9/17/25. Her 9/30/25 BIMS assessment score was a 13, which indicated her cognition was intact. 4. Observation on 9/29/25 at 3:00 p.m. of resident 50's room revealed: *The resident was not in his room. An oxygen concentrator at the foot of his bed and was turned on. *The nasal cannula and tubing attached to the oxygen concentrator was draped over resident 50's unmade bed. 5. Observation on 9/29/25 at 4:25 p.m. of resident 50 in his room revealed him sitting in a wheelchair beside his bed wearing the nasal cannula. 6. Observation on 10/2/25 at 8:37 a.m. of resident 50's room revealed his nasal cannula and tubing was lying on the floor behind his oxygen concentrator. 7. Observation on 10/2/25 at 10:13 a.m. of resident 50 in his room revealed him sitting in his wheelchair beside his bed, wearing a nasal cannula. Review of resident 50's EMR revealed: *He was admitted on 11/18/19. *His 8/1/25 BIMS assessment score was 6, which	F0695	at our ad hoc weekly QAPI meeting on 12/15/25 and audits changed to ten audits every two weeks for four weeks. Follow up and/or education will be provided as needed by the Medication Aid assigned to the audits, the DON or the ID RN. The DON or designee will ensure all audits are being conducted, track progress and brought to QAPI meetings for further recommendations.	

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F0695 SS = D	Continued from page 17 indicated his cognition was severely impaired. *His diagnoses included respiratory failure (a condition when the lungs cannot properly exchange gasses resulting in abnormal levels of carbon dioxide). 8. Observation and interview on 9/30/25 at 11:18 a.m. with resident 5 in her room revealed: *She was seated in a recliner. A nebulizer machine was on the bedside table next to the recliner. The nebulizer mask had a hazy appearance and appeared to have residue on it. Resident 5 stated that a staff member would place the nebulizer mask on her face at the start of the treatment, and she would remove it and place it on the table when the treatment was completed. *A CPAP machine was on a small dresser. The water reservoir of the CPAP appeared to be dry. Resident 5 stated that she did not use the CPAP machine because she needed water in the reservoir, as her mouth and throat became too dry without it. She said that the night staff would not assist her with filling the water reservoir and told her that she did not need water in it. *There was an oxygen tubing and a nasal cannula stored on top of a puzzle that was on a card table. Resident 5 stated that the cannula and tubing were used for her portable oxygen concentrator. The placement of the nasal cannula on the puzzle posed a risk for the nasal cannula to become soiled. When the nasal cannula was later placed in resident 5's nose she would be exposed to the soiled nasal cannula. Review of resident 5's EMR revealed she was admitted on 3/7/25. Her 7/29/25 BIMS assessment score was a 15, indicating her cognition was intact. 9. Observation on 9/29/25 at 3:06 p.m. of resident 42's room revealed: *There was a nebulizer machine with an assembled nebulizer administration set (the cup and mouth piece or mask attached the nebulizer machine to hold and dispense the inhaled medication) on his bedside table. *There were clear liquid drops inside of the nebulizer administration set. Observation on 9/30/25 at 8:00 a.m. of resident 42's room revealed: *The assembled nebulizer administration set was on the	F0695		

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F0695 SS = D	Continued from page 18 side of his nebulizer machine. *There was a small amount of clear liquid inside the nebulizer administration set. 10. Observation and interview on 9/30/25 at 2:05 p.m. with resident 42 in his room revealed: *He administered his nebulizer medication after the nurse placed medication in the nebulizer administration set. *Once the nebulizer treatment was completed, he would place the nebulizer administration set on the side of the nebulizer machine. *He stated licensed practical nurse (LPN) M would come back after he finished his nebulizer treatment, and she would rinse his nebulizer administration set but some of the other nurses did not. 11. Observation and interview on 10/2/25 at 9:01 a.m. with resident 42 in his room revealed: *The nebulizer administration set was on the side of his nebulizer machine. *The nebulizer administration set had clear liquid drops inside the medication chamber and mouthpiece. *Resident 42 stated his nebulizer administration set was cleaned last night, but it was not cleaned after his morning nebulizer treatment, which he received around 7:00 a.m. that day. Review of resident 42's EMR revealed he: *Was admitted on 8/22/24. *Had a 9/11/25 BIMS assessment score of 15, which indicated he was cognitively intact. *Had a 4/8/25 physician's order for "albuterol/ipratropium [a medication used to open the air passages in the lungs to make it easier to breathe] 3 ML [milliliters] neb [nebulizer] [Duoneb] 3 ML INH [inhaled] TID [three times per day]". 12. Interview on 10/1/25 at 1:39 p.m. with registered nurse (RN)/quality and infection prevention supervisor B revealed: *Nebulizer administration sets were to be disassembled, rinsed with sterile water or distilled water, and	F0695		

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F0695 SS = D	Continued from page 19 placed on a towel to air dry after each use by the nurse or certified medication aide. *Nebulizer administration sets were to be washed with soap and water every night at bedtime. *Nebulizer administration sets were to be replaced weekly and as needed if they became soiled. *Nasal cannulas were to be stored in the plastic bag attached to the resident's oxygen concentrators when not in use to prevent contamination of the nasal cannula. *She expected oxygen concentrators to be turned off when they were not in use. *She agreed that a nasal cannula draped over a resident's bed or on the floor had the potential of having become contaminated and should have been replaced. 13. Interview on 10/2/25 at 8:59 a.m. with certified nursing assistant (CNA) P revealed: *Nasal cannulas were to be rolled up and placed in the plastic bag on the resident's oxygen concentrator when it was not in use. *Staff were to assist resident 50 with his nasal cannula and to turn his oxygen concentrator on and off. 14. Interview on 10/2/25 at 9:04 a.m. with RN E revealed: *Nebulizer administration sets were to be rinsed after the administration of the nebulizer medication was completed by the nurse or certified medication aide. *Nasal cannulas were to be stored in the plastic bag attached to the resident's oxygen concentrator when it was not in use. *Resident 42 would turn off his nebulizer once he completed his nebulizer treatment and place the nebulizer administration set on the side of the nebulizer machine. *RN E would return to resident 42's room later in the morning, disassemble his nebulizer administration set, rinse it, and place it on a towel to dry. *Resident 50 was not able to turn his oxygen concentrator on or off or to put his nasal cannula on,	F0695		

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F0695 SS = D	Continued from page 20 remove it, and store it without staff assistance. 15. Review of the provider's 5/22/25 Respiratory Equipment Care policy revealed: *"CPAP/BIPAP -1. Clean according to manufacturer's instructions for use (MIFU) if available. If no MIFU is available: -2. Daily – wipe out the mask with a clean wash cloth [washcloth] and empty water chamber -3 Weekly – a. soak mask and head gear with mild soap and water for 30 minutes, wash, rinse and air dry" *"Nebulizers -1. Clean according to manufacturer's instructions for use (MIFU) if available. If no MIFU is available: -2. Rinse after every treatment a. Empty excess fluid b. Rinse nebulizer with sterile (preferred) or distilled water c. shake off excess moisture d. Store --i. place on a clean, dry paper towel (change the paper towel after each treatment) and store in a clean, dry location in the resident's room to air dry for the next treatment OR --ii. in a designated vented respiratory bag that is changed weekly. -3. Daily, or more often when visibly soiled, disassemble and wash with soap and water, rinse and air dry as above... -5. Discard and replace with new Nebulizer set if grossly contaminated with the patient's secretions, it malfunctions, or is dropped on the floor". Review of the provider's December 2024 Oxygen Therapy policy revealed: *"Oxygen is administered to residents per physician	F0695		

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F0695 SS = D	Continued from page 21 order". *"Procedure for use of concentrators:" -"Procedure for cleaning and maintenance of concentrator:" --"Filters are washed weekly with tubing change." --"Humidifier jars are changed weekly when used." --"Cannula and tubing are changed weekly." --"The above procedures will be documented weekly in the EMR."	F0695		
F0725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by:	F0725	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Avera LTC-Call Lights policy was reviewed on 10/13/2025 by the IDT team during an ad hoc QAPI meeting, no changes needed. Residents 30, 34, 45, 55, 71, 73 and 76 were reviewed by the DON and ID RN on 12/19/25. Resident #30 was discharged on 12/7/25, however he was interviewed on 10/1325 by a member of the Activity team. Follow up was provided by the DON on 10/23/25. Resident #45 was discharged on 11/25/25, however she was interviewed on 10/6/25 by the AC. Follow up was provided by the DON on 10/20/25. Resident #55 was discharged on 10/16/25, however she was interviewed by the SW on 10/15/25. The only complaint was cold food, the dietician was notified for follow up. Resident #73 was	01/24/2026

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F0725 SS = E	Continued from page 22 Based on interview, observation, record review, call light report review, and policy review the provider failed to ensure prompt staff response to resident call lights for seven of seven residents (30, 34, 45, 55, 71, 73, and 76) who complained of slow responses to call lights. Findings include: 1. Interview on 9/29/25 at 4:26 p.m. with resident 71's husband in the hallway revealed: *He turned on his wife's call light when she was incontinent and needed staffs assistance, and it took the staff over 45 minutes to help his wife. *His wife was dependent on the staff to have her incontinence brief changed as she was immobilized. Observation on 9/30/25 at 8:44 a.m. of resident 71 in her room revealed: *She was sitting in a wheelchair, chewing on her clothing protector, and did not verbally respond to questions. Review of resident 71's EMR revealed: *She was admitted 6/9/21. *Her 8/15/25 BIMS score was 0, which indicated her cognition was severely impaired. *She had diagnoses of Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), urinary incontinence, and a history of urinary tract infections. 2. Observation and Interview on 9/29/25 at 4:28 p.m. with resident 76 in her room revealed she: *Was sitting in a wheelchair. *Reported she had to wait a while for the staff to answer her call light, especially in the morning. *Missed going for a walk when she had to wait for staff assistance. *Complained to a staff member about the long call light wait times, but she was unsure who she told.	F0725	discharged on 12/9/25, however he was interviewed on 10/7/25 by the ID RN. Follow up was provided by the dietician on 10/20/25. Resident #34 was interviewed on 10/7/25 by the SW. Followed up by the Dietician on 10/20/25 and by the DON on 10/22/25. This resident was followed up with by the DON again on 12/19/25 and said call light times have improved. Resident #71 was not interviewable; however a skin assessment was completed on 10/15/25, skin documented as unimpaired. The resident's husband was interviewed by DON and stated the call light times have improved and he didn't have any additional concerns. Resident #76 was interviewed on 10/13/25 by the AS. Follow up was provided on 12/20/25 by the Administrator. This resident was followed up again on 12/19/25 by the DON. Resident stated that call light times and noise at night have improved. All residents with a BIMS greater than eight were interviewed by our Social Worker, Activities Supervisor or designee. Residents with a BIMs under 8, the resident representative will be interviewed by SW or designee. Follow-up will be provided to resolve any complaints regarding call light response times. Any trends or patterns identified will be reviewed at QAPI for recommendations. DON met with the Maintenance Director to learn how to pull call light logs for review. A twenty-four-hour log was printed and reviewed for learning purposes and findings shared with our IDT on 10/7/2025 for learning purposes. An additional 18 pagers have been provided to CNAs, nurses and other supportive staff to assist with call light response times. DON provided education to nurse leaders (ID RN, RCC's, the Minimum Data Set (MDS) nurse and the social worker on how to pull call logs as needed for review and follow up when there is a call light concern or complaint by a resident/representative. All current residents at the facility were interviewed by our Social Worker, Activity Director or designee to identify concerns or complaints; follow-up provided for all resident concerns or complaints. Residents	

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F0725 SS = E	Continued from page 23 Review of resident 76's EMR revealed: *She was admitted on 2/1/23. *Her 7/24/25 BIMS score was 15, which indicated her cognition was intact. *She had diagnoses of major depressive disorder (a mental health condition characterized by persistent sadness or a loss of interest in activities, significantly affecting how you feel, think, and act), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable worry and fear about everyday situations), spinal stenosis (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves), spondylolisthesis (a spinal condition where vertebra slips out of its proper position and moves forward onto the vertebra below it), and dependence on supplemental oxygen (the need for oxygen to treat conditions where the body's tissues are not getting enough oxygen). Review of resident 76's 9/15/25 care plan revealed that staff were to encourage her to use her call light to communicate her needs. 3. Observation and Interview on 9/30/25 at 8:20 a.m. with resident 30 in his room revealed: *He was lying in bed watching television. *He received hospice services. *He had to wait 45 minutes in the middle of the night after he was incontinent of bowel, and that made him feel mad. *Staff took a while sometimes during the day to answer his call light, but it was mostly at night when he had to wait for staff assistance. Review of resident 30's EMR revealed: *He was admitted to the facility on 5/29/25. *His 9/25/25 BIMS score was 15, which indicated his cognition was intact. 4. Observation and interview on 9/30/2025 at 8:33 a.m. with resident 34 in her room revealed: *She was in her wheelchair watching television.	F0725	will be interviewed by Activities, SW or designee quarterly to identify and resolve resident concerns or complaints. Education to all staff on the "LTC Call Light" policy and AIDET (Acknowledge, introduce, duration, explanation and thank you) training. Any employee who does not meet the deadline for training will be removed from the schedule until completed. Audits of call lights were conducted starting on the week of 10/21/2025 by the MDS Nurse/RCC/ID RN/DON to ensure that resident call lights are acknowledged, tracked and addressed timely. Audits were conducted for three, 24-hour time frame periods per week for six weeks. Findings will be shared at our ad hoc weekly QAPI meetings and at our quarterly QAPI meetings. Follow up and/or education was provided as needed. On 12/15/25, ad hoc QAPI committee reviewed the audits and moved audits to four times, every two weeks for four weeks. The DON or designee will ensure all audits are being conducted and track our progress and brought to QAPI meeting for further recommendations.	

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F0725 SS = E	Continued from page 24 *She said she waited 30 to 40 minutes at dinner time and supper time for her call light to get answered from the staff. *The staff told her they did not have enough help for the people who needed assistance. *She felt that made the other residents have to wait to go to meals and use the bathroom. *She stated she had to wait the longest for help from the staff at night. *There were times, at night, when she could not hold her urine any longer waiting for staff to bring her a bedpan. *Staff would answer her call light and say they would be right back, but she would have to turn her call light back on to get them to come back and help. *She felt it affected her dignity to have that happen to her. Review of resident 34's electronic medical record (EMR) revealed she had a BIMS (Brief Interview for Mental Status) score of 15 which indicated she was cognitively intact. 5. Observation and Interview on 9/30/25 9:06 a.m. and 10/1/25 at 3:59 p.m. with resident 55 in her room revealed she: *Was sitting in her wheelchair and had on a CAM boot (a device to protect and immobilize the leg after injury or surgery) on her left leg, and a wound vacuum (a device that uses gentle suction to help wounds heal) tubing coming out from that. *Reported she had to wait up to 30 minutes for her call light to be answered by staff at night. *Had been incontinent (involuntary leakage) of urine when she had to wait a while for staff to assist her to the bathroom, and that made her feel embarrassed. *Required staff assistance to use the bathroom due to the wound on her leg that required a wound vacuum, and she was unable to bear weight on her left leg without the CAM boot on. *Needed the staff's assistance to put her CAM boot on and to take it off.	F0725		

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F0725 SS = E	Continued from page 25 *Took herself to the bathroom at night at times when she did not have her CAM boot on because she had to wait a while for staff and did not want to be incontinent. *Previously notified the old director of nursing and her assistant B about her long call light times and needing to take herself to the bathroom without her CAM boot on when staff did not answer her call light quickly enough. Review of resident 55's EMR revealed: *She was admitted to the facility on 8/5/25. *Her 8/15/25 BIMS score was 15, which indicated she was cognitively intact. *Her diagnoses included a healing fracture (broken bone) to her left lower leg, a sprain to her left ankle (injury to the joint causing overstretching or tearing of the ligaments), a history of falls, an overactive bladder (a condition characterized by a sudden, urgent, and frequent need to urinate, often leading to involuntary leakage), muscle weakness, and a need for assistance with personal care. Review of resident 55's 8/25/25 care plan (personalized plan that addresses the resident's care needs, goals, and interventions) revealed: *Per her orthopedic doctor, physical therapy, and occupational therapy, the staff were to put her CAM boot on before transfers, as she could bear weight on her left leg during stand pivot transfers only, if she had it on. *She required staff assistance with her activities of daily living (ADL) related to impaired mobility related to surgery on her left ankle. *Staff were to encourage her to use her call light and assist her to the bathroom. 6. Observation and interview on 9/30/25 at 9:36 a.m. with resident 45 in her room revealed: *She was resting in her recliner. * She waited a long time for staff to respond to her call light at times, especially when other residents were being assisted in the dining room. *She got "disgusted" when she waited a long time for	F0725		

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F0725 SS = E	Continued from page 26 staff to help her get to activities and meals. *She felt sorry for the residents who depended on staff to help them to the bathroom because she thought they waited a long time for help. Review of resident 45's EMR revealed: *She had a BIMS score of 15 which indicated her cognition was intact. *She was a total assist for transfers. 7. Observation and interview on 9/30/25 at 3:35 p.m. with resident 73 in his room revealed: *He was sitting in his recliner. *He stated he waited long periods of time to get help from staff, especially during meals. *He felt irritated when no one would answer his call light because he depended on staff for help. Review of resident 73's EMR revealed: *He had a BIMS score of 15 which indicated his cognition was intact. *He was an assist of one for transfers. 8. Interview 10/1/25 at 8:32 a.m. with certified nursing assistant (CNA) R revealed: * When a call light was turned on by a resident, it sent a notice to staff pagers, was on the screen in that hallway that beeped, and it was displayed on the computers at the end of each hallway. *When a call light was turned on, and she was in another resident's room, she would leave that resident's room to go check on the call light or would call someone on her work phone to assist that resident. *When college started in the fall, the staffing level in the facility was worse, but it was improving. *She felt the staffing levels at night had been good. 9. Interview on 10/2/25 at 7:30 a.m. with night shift CNA EE revealed: *There were typically four CNAs scheduled to work the	F0725		

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F0725 SS = E	Continued from page 27 overnight shift, and she felt they had enough staff working the overnight shifts to meet the residents' needs. *Only a few overnight nurses would help the CNAs answer call lights. *Regarding resident 30: - She felt he was not nice to staff, particularly staff of color. -If staff did not answer his call light within three minutes, he would bang his call light on his bedside table. -He did not sleep at night and turned his call light on for snacks, pop, to empty his urinal, and to change his brief. -She told him she could not be there every two minutes to help him. When he was rude to her, she asked him not to talk to her like that, and she told him she would leave his call light on if he talked to her that way. 10. Interview on 10/2/25 at 8:05 a.m. with CNA Q revealed: *Call lights should be answered within 10 minutes. *If a resident's call light was on when she was busy, she would go acknowledge the resident, turn their call light off, and tell them she would be back to help them. 11. Interview on 10/2/25 at 8:20 a.m. with social worker G revealed: *Resident 55 reported to her a few weeks ago that she was having trouble with the care she received from an overnight CNA. Administrator A followed up, and education was provided to that CNA. *She received complaints regarding long call light response times a few times, and she talked to that resident about that. The resident care coordinator, for that resident, would run a call light report and then talk to the staff. 12. Interview on 10/2/25 at 8:46 a.m. with CNA S regarding residents' call lights revealed: *The staff were expected to answer call lights in a timely manner.	F0725		

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F0725 SS = E	Continued from page 28 *She thought a timely manner meant five minutes or less. *She knew the residents' call lights were on longer around mealtimes when the residents that needed assistance with dining were a priority. 13. Interview on 10/2/25 at 9:18 AM with RN/unit coordinator F regarding call lights revealed: *Staff were expected to answer call lights in a timely manner to ensure the residents' needs were being met. *She was unsure if there was an actual expected time frame that would mean in a timely manner. 14. Interview on 10/2/25 at 9:24 a.m. with RN resident care supervisor C regarding residents' call lights revealed: *She thought an average of ten minutes was the expectation for staff to answer call lights. *The quality and infection prevention supervisor could print out the call light reports, and she would monitor those reports. *the reports were reviewed monthly or if there was a concern from a resident. *Call lights were a priority to ensure they were meeting the residents' needs. 15. Review of the call light alarm report for resident 34 from 9/1/25 through 10/1/25 revealed there were 60 instances where the call light wait time was from 20 minutes up to 1 hour and 33 minutes. 16. Review of the call light alarm report for resident 45 from 9/1/25 through 10/1/25 revealed there were 50 instances where the call light wait time was from 20 minutes up to 2 hour and 5 minutes. 17. Review of the call light alarm report for resident 73 from 9/1/25 through 10/1/25 revealed there were 18 instances where the call light wait time was from 20 minutes up to 52 minutes. 18. Review of the call light alarm report for resident 55 from 9/1/25 through 10/1/25 revealed there were 7 instances where the call light wait time was from 20 minutes up to 35 minutes.	F0725		

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F0725 SS = E	Continued from page 29 19. Review of the call light alarm report for resident 30 from 9/1/25 through 10/1/25 revealed there were 90 instances where the call light wait time was from 20 minutes up to 1 hour and 5 minutes. 20. Review of the call light alarm report for resident 76 from 9/1/25 through 10/1/25 revealed there were 9 instances where the call light wait time was from 20 minutes up to 50 minutes. 21. Review of the call light alarm report for resident 71 from 9/1/25 through 10/1/25 revealed there were 2 instances where the call light wait time was from 20 minutes up to 52 minutes. 22. Interview on 10/2/25 at 10:35 a.m. with RN/quality and infection prevention supervisor B revealed: *Call light issues were reviewed at the montly quality assurance meetings if a concern was identified by a resident. *The expected time for staff to answer call lights was 10 minutes. *She agreed a call light over 20 minutes was to long for residents to wait for assistance. *All staff were expected to answer call lights to ensure the residents' needs were being met. 23. Interview on 10/2/25 at 10:55 a.m. with administrator A revealed: *She expected staff to answer residents' call lights within ten minutes. *Anyone who could help that resident should answer their call lights. *She expected the nurses to complete call light audits for residents with complaints or concerns regarding long call light times. 24. Review of the provider's 2/2025 revised Call Light policy revealed: *"Objective: To respond to patient/resident's requests and needs on a timely basis." *"Procedure: 1. Instruct patient/resident upon admission in regards to use of the call light.	F0725		

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F0725 SS = E	Continued from page 30 2. Answer light promptly. 3. Be courteous when entering room. Ask patient/ resident "May I help you?" 4. Turn off call light. Avoid duplication of services. 5. Listen to patient/resident's request. Do not make him/her feel that you are too busy to help. 6. Respond to request. If item is not available, or request questionable, get assistance from charge nurse. Return to patient/resident with prompt reply."	F0725		
F0732 SS = F	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F0732	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Avera LTC Staffing Guidelines policy was adopted and reviewed on 10/13/2025 by the IDT team during an ad hoc QAPI meeting, final approval with signatures received at our standard monthly QAPI meeting on 10/20/2025. A new form for tracking daily PPD that includes the facility name, date, resident census was created by the DON. Also, includes both the total number and actual hours worked by staff directly responsible for resident care (RNs, LPNs/LVNs, medication aides, CNAs) each shift. PPD forms are now displayed at the entry of the building and at the entry of each unit, updated and posted each day, including weekends by the scheduler or designee in the scheduler's absence. One on one education was provided to the scheduler by the DON. This training included	12/26/2026

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F0732 SS = F	Continued from page 31 (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, document review, and interview, the provider failed to ensure the posted nurse staffing information included the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift, and that the form was posted daily. Findings include: 1. Observation on 10/2/25 at 10:00 a.m. of the provider's nursing services staff posting revealed the number of nursing staff working was listed, but not the number of hours they worked was not included. 2. Interview on 10/2/25 at 11:12 a.m. with registered nurse (RN) health unit coordinator F revealed: *She was responsible for posting the nursing services staff form. *She was not aware of the requirement that the posting was to include the number of hours worked by nursing services staff, including the RN, LPN, and CNAs. *She posted the nursing services staff form daily when she worked, so it was not completed when she was gone, on weekends, or on holidays. 3. A policy that addressed the nursing staff posting was requested, but according to administrator A, the facility did not have a policy regarding that.	F0732	the use of the new PPD form and how to calculate the PPD. The same education was provided to the nurse leaders by the DON. The policy and PPD were reviewed and shared with staff. Five random audits will be conducted per week starting the week of 10/21/2025 for six weeks by the DON/designee to ensure that the PPD is displayed each day. Findings will be shared at ad hoc weekly QAPI meetings and at quarterly QAPI meetings. On 12/15/25 ad hoc QAPI reviewed audits and moved to 5 audits every two weeks for four weeks. Follow up and/or education will be provided as needed. The DON will ensure all audits are being conducted and track our progress. Audits will be brought to QAPI for further recommendations.	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. On 12/19/25, Administrator, Hospitality Services Manager and facility's Dietitian reviewed the following policies, and no	1/30/2026

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F0812 SS = F	Continued from page 32 The facility must - §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: Based on observation, document review, interview, and policy review, the provider failed to: *Ensure appropriate hand hygiene was performed by six dietary staff (K, T, U, BB, and CC) to meet professional food cleanliness standards. *Maintain three of three dishwashers and three of three sanitation solution containers in a manner that met professional food service sanitation standards. Findings include: 1. Interview on 9/29/25 at 4:32 p.m. with resident 67 revealed she: *Preferred to eat her meals in her room. *Stated her food was often cold when she received it in her room. *Told the kitchen staff that her food was often cold, but no one had followed up with her regarding that concern, and her food continued to be delivered to her cold. 2. Review of the provider's 2025 monthly resident	F0812	changes were necessary: "LTC Food Safety & Sanitation – System Standard Policy", "Washing, Rinsing Table/Countertops", and "Handwashing". The following policies were revised and will be brought to ad hoc QAPI for approval: "Manual Ware Washing and Sanitation", "Recording Hot-Cold Food Temperatures", and "Cooking/Cooling of Meats". The following policies are redundant and retired: "Food Handling", "Dishwashing" and "Food Temperatures". Dietitian has met with residents 67 and 53 to resolve food concerns. Resident 55 no longer resides at the facility. The Hospitality Services Manager or designee will attend Resident Council meetings and address any food concerns. Resident Satisfaction Surveys have been conducted by the SW or designee and any food concerns addressed by the Hospitality Services Manager or Dietician. Resident Satisfaction Surveys will be conducted quarterly by SW, Activity Director or Designee. Any trends or patterns identified will be reviewed at QAPI for recommendations. Employees K, T, U, BB, and W will be retrained and demonstrate competency on hand hygiene and glove use. Employee CC/V is no longer employed at Avera Mother Joseph Manor. Employees K, U, GG and DD will be provided education on taking and recording food temperatures on both hot and cold food including altered and modified diets. Any food out of the required temperature range will be reheated, chilled, rechecked and documented prior to service or discarded. Employee DD will be educated on sanitizer solution for the three-compartment sink. All dietary employees will be educated on "LTC Food Safety & Sanitation System Standard Policy", "Washing, Rinsing Table/Countertops", "Handwashing", "Manual Ware Washing and Sanitation", Recording Hot-Cold Food Temperatures" and "Cooking/ Cooling of Meats" by the Hospitality Services Manager and Dietician. Any employee not completing the required by the deadline will be removed from the schedule. Plate warmers are now being utilized on all	

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F0812 SS = F	Continued from page 33 council meeting minutes revealed: *At the 2/19/25 resident council meeting an identified concern was that the "Scalloped potatoes are never done" *At the 6/18/25 resident council meeting an identified concerns was that the "Food temps [temperatures] need to be hotter" -The response to this concern was that a plate warmer and another food warmer was being ordered. 3. Interview on 9/29/25 at 4:04 p.m. with resident 53 revealed: *She ate in the dining room. *The food was sometimes cold when it was served to her, and it sat in the window for a while before it was served by the staff. *Sometimes the noodles were hard, and the meat was difficult to eat. *She thought the kitchen was short of help. A review of resident 55's electronic medical record (EMR) revealed her 9/15/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. 4. Observation on 9/29/25 in the kitchen revealed: *At 4:55 p.m., cook U did not wash his hands before he put on gloves and poured drinks into glasses for the room trays and left them on a cart, uncovered. *At 5:00 p.m. cook U moved food and soup cans from the warmer into the steam table. *At 5:01 p.m., food service worker BB, did not wash his hands before he put on gloves and, then cut strawberries while holding them in his hand. *At 5:02 p.m., hospitality services manager K took off her gloves, did not wash her hands, gathered containers of prepared food, removed utensils from a drawer, and then scooped food into another container and saran-wrapped sandwiches, with her bare, unwashed hands. *At 5:20 p.m., cook U did not wash his hands and took the temperature of the brats, broccoli, and the beans	F0812	three serving areas and thermal base and dome will be utilized on room trays to keep food hot. Cooks/servers will temp food when it comes out of the oven and before serving it. A sample room tray will be dished and temped to verify correct food temperature and then checked again at last delivery to verify the temperature. If either hot or cold food is out of range, corrective action will be taken by server or cook. Cold food will be dished, covered and kept in the cooler until ready to serve. Any food that temps out of the required temperature range will be corrected or discarded. All corrective action will be documented on the temperature log. All food temperatures will be recorded on a log for each meal at each serving area by the cook/ server. Logs will include the unit, date, time, temperature, corrective action and staff's name completing the log. Dishwasher and rinse temperatures will be taken and recorded on a log each mealtime on all three serving areas. The three-compartment sanitation sink and sanitation buckets' chemical concentration will be tested every four hours and recorded on a log. If the water is dirty or out of range, dietary staff will take corrective action and record chemical concentration on the log. Logs will include the unit, date, time, chemical concentration level and staff's name completing the log. Ten handwashing audits will be conducted by the Hospitality Services Manager, Dietitian or Infection Control Nurse weekly for a minimum of twelve weeks. All logs and corrective action will be reviewed daily by the cook and audited three times a week by the Hospitality Services Manager or Designee for twelve weeks. Audits will be brought to QAPI meetings for review and further recommendations.	

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F0812 SS = F	Continued from page 34 before he plated meals for the residents' room trays. *He did not check the temperature of the pork chops, which was an alternate food choice, or the pureed foods. *At 5:34 p.m., just before serving the residents' room trays, surveyors requested food service worker GG to check the temperature of the soup and milk. -The temperature of the chocolate milk was 50.6 degrees Fahrenheit (F), and the chicken noodle soup was 96.9 degrees F. -Food service worker GG was unsure what temperature the milk should have been, but stated she thought it needed to be in the 40s F range. -Hospitality services manager K directed the food service worker GG to dump the warm milk, obtain new milk from the fridge, and to warm up the chicken noodle soup to an appropriate temperature before serving to the resident. *At 5:23 p.m., cook U washed his hands, dried them off on his pants, and then put food containers in the steamer. *At 5:34 p.m., just before serving the residents' room trays, surveyors requested food service worker GG to check the temperature of the soup and milk. -The temperature of the chocolate milk was 50.6 degrees Fahrenheit (F), and the chicken noodle soup was 96.9 degrees F. -Food service worker GG was unsure what temperature the milk should have been, but stated she thought it needed to be in the 40s F range. -Hospitality services manager K directed the food service worker GG to dump the warm milk, obtain new milk from the fridge, and to warm up the chicken noodle soup to an appropriate temperature before serving to the resident. *At 5:38 p.m., cook U pushed his glasses up on his nose frequently while plating residents' meals and did not wash his hands. *At 5:38 p.m., cook U opened the tomato and chicken noodle soup cans, checked the temperature of the soups, and stated, "It did not meet temp".	F0812		

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F0812 SS = F	Continued from page 35 -He was not sure what temperature the soups needed to be to be safe to serve. -Hospitality services manager K warmed up the soup, rechecked the temperatures and it was above 135 degrees F. *At 6:06 p.m., before cook U plated the pureed foods, surveyors requested him to check the temperature of those foods. The pureed meat was chicken, and it was 114 degrees F. The pureed broccoli was 118 degrees F. -He was unsure what temperature those foods needed to be. -Hospitality services manager K warmed up the food so it was above 135 degrees F. *At 6:11 p.m., before cook U plated a pork chop, surveyors requested and had him take the temperature of the pork chops. The pork chops' temperature was 109 degrees F. -Hospitality services manager K warmed up the pork chop to above 135 degrees F. 5. Interview on 9/30/25 at 9:06 a.m. with resident 55 revealed: *She ate in the dining room. *She felt the hot food was sometimes served cold, and the milk was sometimes served warm. A review of resident 55's electronic medical record (EMR) revealed her 8/15/25 BIMS assessment score was 15, which indicated her cognition was intact. 6. Observation on 9/30/25 in the kitchen revealed: *At 11:04 a.m., food service worker W took her gloves off, did not wash her hands, touched her hands on her glasses and pants, and then pureed (blended to a smooth consistency) angel food cake in a blender. *At 11:14 a.m., hospitality services manager K touched her glasses, did not wash her hands, took bowls of food out of the warmer, checked the temperature of the food in those bowls, and placed them back into the warmer. *At 11:20 a.m., cook T finished wiping the counters with a wash rag, did not wash her hands, opened a bag of dinner rolls, put on gloves, took the dinner rolls out of the bag, put them into a container, removed food	F0812		

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F0812 SS = F	Continued from page 36 containers from the warmer, checked the temperature of the food from the warmer, and then put the containers of food back into the warmer. *At 11:21 a.m., cook CC took his gloves off, did not wash his hands, wiped his nose on his forearm, and put clean dishes away. *At 11:39 a.m. hospitality services manager K took the food out of the warmer, which was at the appropriate temperature, and placed it in the steam table to serve. *At 11:42 a.m., hospitality services manager K, did not wash her hands, plated residents' food for residents' room trays, touched her glasses, and continued to plate food for residents in the main dining room while touching her glasses many times without washing her hands. *Hospitality services manager K started to serve residents lunch in the main kitchen at 11:48 a.m. *At 12:17 a.m., without checking the food's temperature, she started to serve pureed noodles, meat, and cauliflower. -The meat temperature was at 140 degrees, the noodles at 136 degrees, and the cauliflower was at 129 degrees. -She thought the food needed to be between 140-145 degrees, so she rewarmed all the food before serving it to the residents. -Those food items were in an uncovered bowl that was in a shallow pan on the steam table, which was covered with a metal lid. 7. Review of the August 2025- September 2025 food temperature logs revealed: *For the Dakota dining room: -From 8/1/25-8/29/25 holding (before serving) food temperatures were not documented eighteen times that month. -From 9/22/25-9/30/25 holding food temperatures were not documented five times. -The following did not meet the required holding temperature of 135 degrees, per the food service code: - On 9/26/25 at dinner time, the cauliflower was 116 degrees, the fish-herb and lemon was 116 degrees, and	F0812		

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F0812 SS = F	Continued from page 37 the mashed potatoes were 131 degrees. -On 9/28/25 at dinner, the meat lovers pizza was 120 degrees. -On 9/29/25 at dinner, broccoli with cheese sauce was 125 degrees, and the pork roast with noodles and sauce was 105 degrees. -No corrective action was documented for any of the above low food holding temperatures. *For the main dining room: -From 8/1/25-8/31/25 the cooking temperatures were not documented 36 times. -From 8/1/25-8/31/25 the holding temperatures were not documented 63 times. -From 9/13/25-9/30/25 the cooking temperatures were not documented 23 times. -From 9/13/25-9/30/25 the holding temperatures were not documented 37 times. -On 9/28/25 at dinner, the vegetable blend was 116 degrees. -There was no documentation of corrective action taken for the low food temperature. 8. Review of the provider's May 2025-September 2025 dishwasher temperature and sanitizing solution logs on the Cedar wing revealed: *The "Quaternary and Water Temperature Monitoring Form" indicated the test strip results should be between 200-400 parts per million (ppm) and the water temperature should be between 65-85 degrees. *The May 2025, June 2025, and July 2025 sanitation solution logs were not provided for review. *The sanitation solution was not documented as checked 119 times in August 2025 and 62 times in September 2025. *The dishwasher temperature log for August 2025 was not provided for review. *The dishwasher temperatures were not documented 26 times in May 2025, 12 times in June 2025, 8 times in July 2025, and 6 times in September 2025.	F0812		

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F0812 SS = F	Continued from page 38 *The dishwasher wash temperature did not meet the required temperature on 6/22/25, 7/6/25, 9/2/25, 9/10/25, 9/14/25, 9/15/25, 9/17/25, 9/24/25, and 9/27/25. *The dishwasher rinse temperature did not meet the required temperature on 6/14/25, 6/16/25, 6/20/25, 6/22/25, 7/3/25, 7/6/25, 7/14/25, 7/19/25, 7/21/25, 7/22/25, 7/25/25, 9/2/25, 9/3/25, 9/4/25, 9/10/25, 9/12/25, 9/13/25, 9/14/25, 9/15/25, 9/17/25, 9/18/25, 9/24/25, 9/26/25, and 9/27/25. -There was no documentation that any corrective action was taken to resolve the temperatures that were out of range. 9. Review of the provider's May 2025-September 2025 dishwasher temperature logs and sanitation solution logs on the Dakota wing revealed: *The sanitation solution was not documented as checked 118 times in May 2025, 109 times in June 2025, 120 times in July 2025, 100 times in August 2025, and 88 times in September 2025. *The dishwasher temperatures were not documented 31 times in May 2025, 14 times in June 2025, 11 times in July 2025, 11 times in August 2025, and 18 times in September 2025. *The documented rinse temperatures did not meet the required temperature on 5/28/25 and 5/29/25, 6/12/25, and 6/29/25. -There was no documentation that any corrective action was taken to resolve the temperatures that were out of range. 10. Review of the providers' May 2025-September 2025 dishwasher temperature logs and sanitation solution logs for the main kitchen revealed: *" Instructions: Dip QUATS test QUAT solution (Not foam surface) for ten (10) seconds, Do not shake; compare colors to color guide at once. Parts Per Million (PPM) must be a minimum of: 300. Record Sanitizer concentration." *The May 2025, June 2025, July 2025, and August 2025 sanitation solution logs were not provided for review. *The sanitation solution was not documented as checked 70 times in September 2025 and did not meet the	F0812		

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F0812 SS = F	Continued from page 39 required sanitation level on 9/19/25 and 9/22/25. -There was no documentation that corrective action was taken to resolve the sanitization level that was out of range. *The dishwasher temperatures were not documented 28 times in May 2025, 22 times in June 2025, 18 times in July 2025, 32 times in August 2025, and 25 times in September 2025. *The dishwasher did not meet the required wash temperature on 5/10/25, 5/22/25, 5/23/25, 6/3/25, 6/16/25 at breakfast and lunch, 6/18/25, 7/5/25, and 8/18/25. *The dishwasher did not meet the required rinse temperature on 5/1/25, 5/5/25, 5/7/25 at breakfast and supper, 5/9/25, 5/10/25, 5/11/25, 5/17/25, 5/18/25, 5/21/25, 5/22/25 at breakfast and lunch, 5/23/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/25, 6/2/25, 6/19/25, 6/22/25, 6/26/25, 6/27/25, 6/28/25, 7/1/25, 7/3/25, 7/6/25, 7/9/25, 7/15/25, 7/17/25, 7/25/25 at breakfast and supper, 8/5/25, 8/6/25, 8/9/25, 8/12/25, 8/14/25 at breakfast, lunch, and supper, 8/16/25, 8/17/25, 8/22/25, 8/25/25, 9/26/25, 9/25/25, and 9/30/25. -There was no documentation that any corrective action was taken to resolve the temperatures that were out of range. 11. Interview on 10/1/25 at 8:13 a.m. with food service worker DD revealed: *She took the holding temperature of the food before each meal. *If the food temperature was out of range, she took that food item back to the kitchen to have it reheated. *She would check the temperature of the altered diets, such as pureed food items, before serving them. *She did not check the temperature of the cold foods. * The dishwasher was a high-temp dishwasher. *The wash temperature was to be 160 degrees, and the rinse temperature was to be 180 degrees, and she would notify maintenance if it did not meet those temperatures. *The wash and rinse temperatures were to be documented	F0812		

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F0812 SS = F	Continued from page 40 at breakfast, lunch, and dinner. *Buckets with sanitizer solution were prepared for use at 6:30 a.m., and changed at 11:00 a.m., and before supper. *She was the one to obtain the sanitation solution and was to document the sanitation level each time it was filled. *The sanitizer solution was to be at 300 ppm, and the water was to be at 75 degrees. 12. Interview on 10/1/25 at 9:05 a.m. with hospitality services manager K and dietician L revealed: *The hospitality services manager was new in her role, and she started at the end of May 2025. *Providing education to dietary employees who were students was difficult, but she will have the leads (supervisors) help with that and provide more supervision. *The temperature of the food should be checked when it was removed from the oven (cooking temperature) and just before serving it (holding temperature) to ensure it was in the safe range. *Food temperatures should be documented on the food temperature logs in the kitchen and each dining room. *If food temperatures were out of range, any staff member was to let the kitchen staff know and bring it back to a safe temperature before serving it. Corrective active steps taken to correct the food temperature should have been documented on the food temperature log, and it was not. *They did not monitor the temperatures of cold foods or the cold drinks. *They acknowledged the warm milk temperature of 50.6 degrees F was not a safe temperature for serving and was considered a potentially hazardous food. *They agreed that if the food temperatures were not at safe serving temperatures and dietary staff did not document if interventions were taken on the food temperature log, then the staff may have served those foods to the residents, which may have put the residents at risk for foodborne illness. *They agreed that if food temperatures were not	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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

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F0812 SS = F	Continued from page 41 documented, they could not be sure they were at a safe temperature to prevent foodborne illness. *Modified diet food temperatures should have been checked and documented on the logs. *They reviewed the food temperature logs and determined which dining area they were from, since they were not labeled, and verified that some of the dates were missing. *Warming soup while still in the can was something hospitality services manager K learned from another cook, and she will no longer warm it up in the can, as the instructions on the soup can were "microwave it by emptying the contents into a microwave-safe bowl or to heat it on the stove by emptying the contents into a small saucepan." *Hospitality services manager K verified she did not check the food temperatures before serving lunch on 9/30/25, and she should have. *The three-compartment sink sanitation level was monitored each time it was changed. *The sanitizer solution in the buckets for each wing's dining room was monitored each time it was changed. *She was not able to find all the sanitation level logs that were requested. *The sanitation solution was to be changed every two to four hours, and as needed if it was dirty. *Staff were to document the sanitation level each time the sanitation solution was changed in the third compartment sink and the buckets. *They verified that staff were not documenting the sanitation solution per policy, and they should have been. *If the sanitation level was out of range, staff were to empty the sanitation solution and retest it. *Sometimes the water did not always function properly when using both the soap and sanitizer solution at the same time. *If the sanitation solutions did not meet the required sanitation level, staff were to put a work order into maintenance so it could be fixed.	F0812		

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F0812 SS = F	Continued from page 42 *They were not able to ensure proper sanitation of the dishes or the wiped surfaces if the sanitation level was not documented as being in the correct range, which could potentially cause residents to be sick. *They expected the dishwasher wash and rinse temperature to be checked and documented at breakfast, lunch, and supper. *The dishwasher temperatures were not always documented and should have been. *She was unable to find all of the dishwasher temperature logs as requested. *They expected the dishwasher wash temperature to reach 165 degrees and the rinse temperature to reach 180 degrees for effective sanitization. *Reviewing policies and log sheets, they verified that the expected dishwasher temperatures did not match. *Hospitality services manager K asked the maintenance supervisor, who said the dishwasher wash temperature was to reach at least 150 degrees. *They verified that not all the documented wash and rinse temperatures met the required temperature to ensure sanitation was achieved. *Maintenance staff were to be notified if the dishwasher wash or rinse temperature did not meet the required temperatures. *There was no documentation that the maintenance staff was notified when the dishwasher did not meet the required temperatures. *They agreed that if the dishwasher temperatures and sanitization solution levels were not checked and documented, they could not ensure effective sanitation of the dishes and equipment used to prepare and serve residents' food, which could make the resident sick. *When asked, hospitality services manager K did not say how often she reviewed at the sanitation solution and dishwasher logs. *They expected handwashing to be performed when staff entered the kitchen, after touching their face, before putting on gloves, after removing gloves, when changing tasks, and when moving from a dirty to a clean task. *They verified, if a staff member dried their hands on	F0812		

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F0812 SS = F	Continued from page 43 their pants, they should wash their hands. 13. Review of the providers' September 2025 Food Temperatures policy revealed: *" All potentially hazardous food must be kept below 41 degrees...during transportation." 14. Review of the providers' May 2024 LTC Food Safety and Sanitation-System Standard Policy revealed: *" Food Safety is paramount to prevent food borne illness....For nursing home residents who are older or sick with compromised immune systems, food borne illness is certainly more serious and may even be life threatening." *" The food safety/sanitation program is designed to identify, implement, monitor, evaluate, and correct food sanitation procedures from food production to food consumption. All local, state, and federal standards and regulations are followed in order to assure a safe and sanitary food service department." * " Responsibilities: -Nutrition Services Director: -Establish and maintain sanitary standards of cleanliness and food handling practices. All Hazard Analysis Critical Control Point (HACCP) procedures are followed. -Provide and document education to employees on personal hygiene, food handling, and sanitation yearly, or as needed...." *" Ensure proper maintenance, operation and cleaning of all equipment." *" Evaluation practices of food handling to meet sanitary standards. *" In collaboration with the Infection Prevention Committee, review and update policies and procedures related to infection control." *" Documentation of education/training is maintained and monitored by department leader." *" Cooked foods must reach the temperature recommended by the Food Service Code." *" Hot food is held at a temperature of 140 degrees or	F0812		

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F0812 SS = F	Continued from page 44 above." *" Cold foods are held at a temperature of 40 degrees or less." *" Anytime a contaminated surface is touched, the gloves must be changed-washing hands after removing the gloves and before putting on a new pair." *" Hands must be washed before serving/distributing meals, & or after picking up soiled plates/waste." *" Sanitizer buckets are changed when visibly soiled or per manufacturer directions. The sanitizer is checked for proper concentration with test tape (per manufacturers [manufacturer's] direction)". *Cloths must be soaking in sanitizer until use, changing solutions every 4 hours to maintain active concentration." *" The dishwasher is maintained and operated according to manufacturer's instructions. -1. Hot water dish machines need to run at 155 [degrees] for wash cycle and minimum of 180 [degrees] for rinse cycle. Always follow manufacturer guidelines to ensure appropriate sanitation levels, regardless of what machine is used. Temperature/appopriate sanitation levels are checked & recorded daily." 15. Review of the providers' September 2025 Food Handling policy revealed: * Staff were to "wash hands prior to preparing, serving and distributing food." 16. Review of the providers' September 2025 Dishwashing policy revealed: *" Wash temperature should reach 150 degree F". *" Rinse temperature should reach 180 degree F." 17. Review of the providers' September 2025 Hand Washing policy revealed: *" Staff will use proper handwashing to prevent the spread of pathogens."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet	01/30/2026

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F0880 SS = D	Continued from page 45 §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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with	F0880	weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Avera LTC-Hand Hygiene policy was reviewed on 10/13/2025 by the IDT team during an ad hoc QAPI meeting, no changes needed. Staff members R, Y, Z and Q were provided with education on hand hygiene and the use of PPE, proper or improper use of gloves by the DON on 12/19/25 and 12/20/25. Staff member R was also educated on enhanced barrier precautions by DON on 12/19/25. Education to all staff on Avera's LTC Hand Hygiene policy will be provided by DON, Infection Control RN or designee. Any employee who does not meet the deadline for this education will be removed from the schedule until completed. Random audits were conducted starting the week of 10/21/2025 by the IP nurse to ensure that staff are following the hand hygiene per policy. Ten audits were conducted weekly for six weeks. 12/15/25 ad hoc QAPI reviewed audits and moved to ten audits every two weeks for four weeks. Findings will be shared at our ad hoc weekly QAPI meetings and at our quarterly QAPI meetings. Follow up and/or education will be provided as needed. The DON/designee will ensure all audits are being conducted and track our progress and brought to QAPI meeting for further recommendations.	

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F0880 SS = D	Continued from page 46 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure standard infection prevention practices were followed by: *Two of two certified nursing assistants (CNA) (R and Y) and 1 of 1 registered nurses (RN) (Z) removed their gloves prior to entering the hallway. *Two of two CNAs (R and Y) and one of one RN (Z) performed hand hygiene (handwashing) prior to the application and after the removal of gloves for one of one residents (51). *One of one CNA (R) who used a phone with soiled gloves while in one of one sampled resident's (51) room who was on enhanced barrier precautions (glove and gown use) after assisting that resident with personal hygiene. Findings include: 1. Observation on 9/30/25 at 9:18 a.m. in the Abby hallway revealed: *CNA Y exited a resident room with a glove on his right hand. *That resident's room had personal protective equipment	F0880		

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F0880 SS = D	Continued from page 47 (such as gowns, gloves, face shield, and masks) (PPE), and a sign posted on the door which indicated a resident who resided in that room was on EBP. *He removed the glove from his right hand and disposed of it in the garbage on the side of the medication cart. *He did not perform hand hygiene after he removed the glove. *Then he opened the doors to three other resident rooms, looked in the rooms, and then closed the doors. 2. Observation and Interview on 9/30/25 at 9:43 a.m. with CNA R in resident 51's room revealed: *Resident 51 was lying in bed, the lights were dimmed, and relaxing music was playing. *Resident 51 would not respond verbally to questions asked. *Resident 51 was on EBP due to having a history of Methicillin-resistant Staphylococcus aureus (MRSA) infection. *Before providing care, CNA R washed her hands and put on a gown and gloves. -She moved the resident's bedding and clothing, then took off her gloves, threw them away, and did not perform hand hygiene. -She put on clean gloves, cleaned the resident's bottom with a wet wipe, then took off those gloves, threw them in the garbage, and did not perform hand hygiene. -She put clean on clean gloves, washed the resident's perineal area (genitals), took off those gloves, threw them in the garbage, and did not perform hand hygiene. -She put on clean gloves, assisted the resident with brushing her teeth, took off those gloves, threw them in the garbage, and did not perform hand hygiene. -She put on clean gloves, washed the resident's face with a washcloth, took a phone out of her pocket, called someone, and asked that person to bring her a clean gown for the resident. -With those same gloved hands, she removed the resident's nasal cannula of oxygen from her nose,	F0880		

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F0880 SS = D	Continued from page 48 applied lotion to the resident's face, took off the resident's gown, applied the resident's deodorant, put a clean gown on the resident, put on her nasal cannula, cleaned the resident's nails, and brushed her hair. -CNA Q entered the room wearing a gown and gloves, and assisted CNA R in repositioning resident 51. -After repositioning resident 51, CNA R took off her gloves, threw them away, and did not perform hand hygiene. -She put on a clean pair of gloves, took a cleaning wipe out of a container, wiped the resident's bedside table off, and then took off her gloves and gown, and threw them in the garbage. -With her ungloved hands, she removed the full garbage bag from the garbage container, replaced it with a new bag, and put the resident's fall mat down on the floor beside her bed. -She then performed hand hygiene and exited the residents' room. *Interview immediately following the above observations with CNA R revealed: *She was to wash her hands before going into a resident's room, before applying gloves, before moving from a clean to dirty task, after removing gloves, and when exiting a resident's room who was on EBP. *She confirmed she had not performed hand hygiene when she moved from a dirty task back to a clean task, when she changed her gloves, and when touching the phone during resident 51's care. 3. Observation on 10/1/25 at 10:59 a.m. of RN Z revealed: *RN Z did not wash her hands and then put on a pair of gloves while in the medication room. *She walked from the medication room to resident 83's room with those same gloves on, opened resident 83's door, and laid out her equipment on resident 83's over the bed table. *RN Z collected blood from resident 83's finger and completed a blood sugar check. *She removed those gloves, threw them in the garbage can while in resident 83's room and did not perform	F0880		

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F0880 SS = D	Continued from page 49 hand hygiene. *RN Z then walked down the hallway to the medication room, put on another pair of gloves without first performing hand hygiene, cleaned the glucometer with a sanitizing wipe, removed those gloves, and then performed hand hygiene. 4. Observation on 10/1/25 at 11:18 of RN Z as she administered a nebulizer (a device that converts liquid medication into an inhalable mist) treatment to resident 49 revealed: *She did not perform hand hygiene prior to preparing the nebulizer medication and placing the nebulizer mask on resident 49's face. She removed her gloves, performed hand hygiene, and then exited the room. *After the nebulizer medication was administered, without first performed hand hygiene, RN Z put on gloves while at the nurse's station, walked down the hall and entered resident 49's room. She removed the nebulizer mask from resident 49's face, rinsed off the nebulizer mask in the resident's sink, removed her gloves and discarded them in the garbage, and then performed hand hygiene. 5. Interview on 10/1/25 at 1:23 p.m. with RN/quality and infection prevention supervisor B revealed: *She expected no gloves to be worn by staff in the hallways due to staff having to touch potentially contaminated surfaces in order to enter a resident room to provide resident care. *Hand hygiene was to be performed before staff put on gloves and after the gloves were removed. *She stated that RN Z should not have been wearing gloves in the hallway before she checked resident 83's blood sugar and before discontinuing resident 49's nebulizer treatment because she expected the staff to put gloves on in the resident's rooms after performing hand hygiene and prior to performing care. *RN/quality and infection prevention supervisor B stated CNA Y should have removed his gloves and performed hand hygiene before exiting the resident's room. 6. Interview on 10/2/25 at 11:22 a.m. with RN/quality and infection prevention supervisor B and interim director of nursing (IDON) aa revealed:	F0880		

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F0880 SS = D	Continued from page 50 *They expected CNAs to perform hand hygiene before putting gloves on and after taking them off. *Before using the phone, staff should have removed their dirty gloves, performed hand hygiene, used the phone, performed hand hygiene again, and then put gloves on. 7. Review of the providers' May 2025 Gloves-LTC Infection Prevention policy revealed: *" Gloves are to be changed between patient contacts and when moving from contaminated to clean tasks for the same patient." *" Hand Hygiene is to be completed before putting on gloves and after removing them." 8. Review of the provider's 11/14/24 LTC-Hand Hygiene policy revealed: *"HH [Hand hygiene] either with soap and water or with alcohol based hand rub (ABHR):...after removing gloves.... 9. Review of the providers October 2024 LTC-Transmission Based Precautions and Enhanced Barrier Precautions revealed: * "Transmission of infectious organisms within a healthcare setting requires three elements to be linked: -A source (or reservoir) of infectious organisms -A susceptible host -A means of transmission of the organism. -Interruption of this link in the chair of infection is achieved primarily by...using a barrier (Enhanced Barrier Precautions)." *" Multidrug Resistant Organism (MDRO): bacteria that are resistant to one or more classes of antimicrobial agents. Examples...MRSA." * "Enhanced Barrier Precautions (EBP): use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing." *"...Facilities will incorporate the use of...Enhanced	F0880		

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F0880 SS = D	Continued from page 51 Barrier Precautions...as indicated for known, suspected or incubating infections, or communicable diseases, and for the protection of residents, visitors, and staff from potential exposure to communicable and transmissible diseases." *" Enhanced Barrier Precautions are used during high contact resident care activities for the following residents and should be implemented as facilities are able: -Infection or colonization with an MDRO when contact precautions do not otherwise apply... -...gown and gloves must be used during high contact care activities including (but not limited to) -dressing -providing hygiene -changing briefs...."	F0880		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 9/30/25. Avera Mother Joseph Retirement Community was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Henrickson	Administrator	12/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A recertification survey was conducted on 9/30/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Mother Joseph Manor Retirement Community Building 1 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 and the Fire Safety Evaluation System (FSES) dated 10/01/25. Please mark an F in the completion date column for K241 and K374 deficiencies identified as meeting the FSES.	K0000		
K0241 SS = C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain a one-hour, fire-resistive path of egress from the second level to the exterior of the building. Two stair enclosures discharged into the main level corridor system. Findings include: 1. Observation on 9/30/25 at 11:30 a.m. revealed the east and west second-level stair enclosures discharged into the main level corridor system. A one-hour, fire-resistive path of egress was not provided to the exterior of the building. Review of the previous life safety code survey confirmed that finding.	K0241		F

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Henrickson	Administrator	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0241 SS = C	Continued from page 1 The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K0241		
K0374 SS = C Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation, measurement, and record review, the provider failed to maintain at least 32 inches of clear width for one set of smoke barrier doors (between the 1961 original building and the 1980 addition) opening. Findings include: 1. Observation on 9/30/25 at 1:45 p.m. revealed the cross-corridor doors from the 1961 original building and the 1980 addition measured 30 inches in clear width. Review of the previous survey report revealed those doors were part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K0374		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - SOUTHWEST WING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 2A	INITIAL COMMENTS A recertification survey was conducted on 9/30/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Mother Joseph Manor Retirement Community Building 2 was found in compliance.	K0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Henrickson	Administrator	12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 3A - NORTHWEST WING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 3A	INITIAL COMMENTS A recertification survey was conducted on 9/30/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Mother Joseph Manor Retirement Community Building 3 was found in compliance.	K0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Henrickson	Administrator	12/26/2025

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
	10590	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COM	1002 N JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 9/29/25 through 10/2/25. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirements: S206 and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section.	S 206	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Education/Development policy was reviewed on 10/13/2025 by the IDT team during an ad hoc QAPI meeting, no changes needed. Employee O is a primary employee of Avera St. Luke's and a secondary employee to Avera Mother Joseph Manor and wasn't assigned the new hire education by the Avera Learning Center. The required education will be assigned to employee O to complete; she has been removed from the schedule until this education has been completed.	1/24/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Paula Henrickson Administrator 12/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10590	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COM	1002 N JAY STREET ABERDEEN, SD 57401

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S 206	Continued From page 1 The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure: *One of five sampled employees (O) had completed the required orientation training topics: emergency preparedness and procedures, infection prevention and control, accident prevention safety procedures, proper restraint use, resident rights, confidentiality of resident information, mandatory reporting incidents and diseases, care of residents with unique needs, dining assistance, nutritional risks and hydration, abuse, neglect, misappropriation, and mistreatment, and advance directives within 30 days of hire date. Findings Include: 1. Review of aide O's employee file revealed she: *Was hired on 11/10/2024. *Had not completed the required orientation training within 30 days of her hire date including: -Emergency preparedness procedures. -Infection prevention and control. -Accident prevention safety procedures. -Proper restraint use. -Resident rights. -Confidentiality of resident information. -Mandatory reporting, incidents and diseases. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation, and mistreatment.	S 206	All employees at the facility were reviewed by the Avera Learning Center and confirmed that all primary employees completed the required education and that secondary employees were not assigned the required education. Secondary employees will have the required education assigned, will be notified and complete all past due education. If this education is not completed by the deadline, the employee will be removed from the schedule until education is completed. Education to all staff on this policy will be provided and any employee who did not meet the deadline will be removed from the schedule until completed. Department leaders with direct reports will work with the Avera Learning Center (ALC) to assign new hire and annual education to secondary employees. ALC will train department leaders to assign and monitor employee education to ensure it is completed timely. All new employees will be audited by the Nurse Educator to ensure that new hire education is completed within 30 days. All employees will be audited to ensure they complete annual education once assigned. Employees who haven't completed the required education by the deadline will be removed from the schedule until it is completed. Findings	

S 206	Continued From page 2 -Advance directives. Interview on 10/1/25 at 2:30 p.m. with human resource officer H revealed: *He confirmed that aide O did not complete the above required orientation training within 30 days of hire. *The provider used an electronic training program, and the education had to be "assigned" to the employee. *New employees were automatically assigned the orientation education by the electronic system based on their position. *He had not assigned the correct employee position to aide O. -Aide O did not have access to the electronic training program to complete the required training because of that error.	S 206	will be shared at our ad hoc weekly QAPI meetings and at our quarterly QAPI meetings for further recommendations.	
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements.	S 301	Ad Hoc QAPI was conducted on 10/7/2025 with members of the Interdisciplinary Team (IDT) to review deficiencies and work on the plan of correction and will continue to meet weekly until completed. All deficiencies and plan of correction will be reviewed in Quarterly QAPI meetings for recommendations. The Education/Development policy was reviewed on 10/13/2025 by the IDT team during an ad hoc QAPI meeting, no changes needed. All dietary staff will be trained on this policy. Employees T and U transferred into the dietary department from another department at Mother Joseph Manor and the required dietary training was not assigned to them. Hospitality Services manager worked with the Avera Learning Center to assign the required dietary courses and they were completed by Employees T and U by 10/31/25. All Food Service Worker's education records were audited by the Hospitality Services Manager to ensure that all required education has been completed. If required education is not	1/9/2026

S 301	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review and interview, the provider failed to ensure two of five sampled dietary employees (T and U) had received initial training on the required topics of handwashing, food handling and preparation, foodborne illnesses, serving and distribution, leftovers, and time and temperature controls. Findings Include: 1. Review of the employer's employee personnel records revealed: *Cook T was hired on 6/22/25, and cook U was hired on 8/3/25. *There was no documentation to support that those two employees had completed the required dietary training on the topics of: -Handwashing -Food handling and preparation. -Foodborne illnesses. -Serving and distribution. -Leftovers -Time and temperature controls. Interview on 10/1/25 with human resource officer H revealed: *The required food safety and foodborne illness education had not been completed by Cooks T and U. *The provider used an electronic training program. *The dietary manager was to assign the training to the dietary employees which would allow the employees to complete the training. *Dietician L or hospitality services manager K had not assigned the required dietary training to cooks T or U.	S 301	complete, they will be removed from the schedule until completed. The Hospitality Services Manager will work with the Avera Learning Center to assign new hire and annual education to all dietary employees who transfer from or work in another department at Avera Mother Joseph Manor. Hospitality Services Manager will audit required education for completion within thirty days of hire and annually once assigned. If the required education is not completed timely, the dietary employee will be removed from the schedule. The Hospitality Services Manager is responsible for compliance and audits will be reviewed at QAPI meetings for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10590	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COM	1002 N JAY STREET ABERDEEN, SD 57401

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S 301	Continued From page 4 Interview on 10/1/25 at 4:00 p.m. with dietician L and hospitality services manager K revealed they were not aware they were responsible for assigning those trainings to the dietary staff.	S 301		