

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	On 5/15/24, the "home" medications for R 68 (43 gabapentin, 300 mg capsules and 50 oxycodon, 5 mg tablets) and "home" medications for R 38 (1 hydrocodone, 5 mg acetaminophen 325 mg tablet) were removed from the medication carts and disposed of according to the facility's "LTC Controlled Substances System Standard Policy" and "Pharmaceutical Services Policy" by two RNs.	06/14/2024
F 755 SS=E	Pharmacy Srvc/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755	On 5/15/24, the expired medication for R 55 (box of Ondansetron 4 mg orally disintegrating tablets); the expired medication for R 8 (Ondansetron 8 tablets) and the expired medication for R 29 (bottle of stomach relief) were removed from the medication carts and disposed of according to the facility's "Pharmaceutical Services Policy". For R 55, R 8 and R 29, an incident report was completed, resident/ representative and physician notified that expired medications were administered. No noted negative impact to resident from receiving expired medications On 5/30/24 all of the facility's medication carts were checked for "home" medications, expired medications and narcotics without a controlled substance record form. One expired medication was discovered, removed and disposed of according to facility's "Pharmaceutical Services Policy" by RN. This expired med had not been utilized during expiration period. On 5/30/24 Facility's "Pharmaceutical Services Policy" was reviewed by Director of Nursing (DON) and Administrator. Policy was revised to include that no "home" medications will be allowed in facility unless unobtainable through LTC Pharmacy. It was also revised to include checking all medication carts for expired medications monthly. DON reviewed the "Controlled Substances Policy" and no revisions were necessary. DON scheduled meeting on 6/5/24 to educate licensed nurses and trained medication aides on the revised "Pharmaceutical Services Policy" and "Controlled Substances Policy". All medication carts will be audited monthly by RN for "home" and expired medications. All narcotics will have a controlled substance record form completed, counted every shift and audited weekly x 4 week, then monthly for 5 months. DON will bring all audits to facility's QAPI committee for further recommendations until facility demonstrates sustained compliance.	

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

TITLE

(X6) DATE

Paula Henrickson, Administrator 05/31/2024

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

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
F 755	<p>Continued From page 1</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure:</p> <p>*Two of two sampled residents (38 and 68) home narcotic medications had been reconciled and accounted for.</p> <p>*Three of five residents (8, 29, and 55) did not receive expired medications.</p> <p>Findings include:</p> <p>1. Observation and interview on 05/15/24 at 10:31 a.m. with registered nurse (RN) C at the medication cart located on the Dakota unit while reviewing the controlled medication reconciliation process revealed:</p> <p>*The locked controlled medication drawer contained:</p> <p>-Two bottles of resident 68's medications in a biohazard bag.</p> <p>--One bottle contained 43 gabapentin 300 milligrams (mg) capsules.</p> <p>--The second bottle contained 50 oxycodone 5 mg tablets.</p> <p>--The sheet of paper was dated "4/17/24" and contained a handwritten note "Send home with family."</p> <p>*RN C stated the medication had been removed from resident 68's room and placed in the medication cart.</p> <p>*There was no controlled substance record form to confirm the count of the controlled medication.</p> <p>2. Observation on 5/15/24 at 10:59 a.m. with RN D at the medication cart located on the Abby unit while reviewing the controlled medication</p>	F 755		

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
F 755	<p>Continued From page 2</p> <p>reconciliation process revealed:</p> <ul style="list-style-type: none"> *The locked controlled medication drawer contained: <ul style="list-style-type: none"> -A home medication bottle with a sheet of paper attached to it with a rubber band. --The bottle contained one hydrocodone 5 mg acetaminophen 325 mg tablet. --The sheet of paper dated "4/19" identified the medication belonging to resident 38 was to have been sent home with family. *There was no controlled substance record form to confirm the count of the controlled medication. <p>3. Interviews on 5/15/24 at 10:35 a.m. and again at 11:05 a.m. with director of nursing (DON) B revealed:</p> <ul style="list-style-type: none"> *A controlled substance sheet should have been started when the medications were found. *Controlled substance medications from home should have been counted to confirm the amounts of those medications each shift. *The medications should have been sent home or destroyed. <p>4. Review of the provider's 4/2024 LTC Controlled Substances -System Standard Policy revealed:</p> <ul style="list-style-type: none"> *"It is the policy of [the provider] to properly acquire, receive, store, administer, track, reconcile, document, and dispose of controlled substances ..." *"To accurately account for and reconcile controlled substances for prompt identification of loss or potential diversion." <p>5. Observation and medication administration record (MAR) review on 5/15/24 at 10:59 a.m. with RN D at the medication cart located on the Abby unit revealed:</p> <ul style="list-style-type: none"> *Resident 55's box of ondansetron 4 mg orally 	F 755	

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
F 755	<p>Continued From page 3</p> <p>disintegrating tablets was marked as opened on 9/20/22 and expired on 4/30/24.</p> <p>-The last dose was provided on 5/9/24 at 8:25 a.m.</p> <p>*Resident 8's ondansetron 8 mg tablets that expired on 3/28/24.</p> <p>-The last dose was given on 5/13/24 at 12:40 a.m.</p> <p>6. Observation and MAR review on 5/15/24 at 11:05 a.m. with RN E at the medication cart located on the Boardwalk unit revealed: *Resident 29's bottle of stomach relief opened on 9/9/23 and expired on "1/24". -The last dose was provided on 5/10/24 at 5:18 a.m.</p> <p>7. Interview on 5/16/24 at 11:17 a.m. with DON B revealed she: *Was unaware the above residents had been given expired medications. *Would have expected expired medications to have been removed from the medication cart and sent back to the pharmacy. *Would have expected an incident report to have been completed, and the residents, the residents' family members, and the residents' physician to have been notified that they were given expired medications.</p> <p>8. Review of the provider's 12/2022 Pharmaceutical Services policy revealed: *"Medications having an expiration date will be checked periodically, properly disposed of if the expiration date has been reached, and replaced as indicated."</p>	F 755		

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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)
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 5/13/24 through 5/16/24. Avera Mother Joseph Manor Retirement Community was found in compliance.	E 000	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Paula Henrickson, Administrator 05/31/2024

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

MAY 31 2024
SD DOH-OLC

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted 5/14/24. 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 5/16/24. Please mark an F in the completion date column for K241 and K374 deficiencies identified as meeting the FSES.	K 000		
K 241 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 REQUIREMENT 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:	K 241		F

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

TITLE

(X6) DATE

Paula Henrickson, Administrator 05/31/2024

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

MAY 31 2024

SD DOH-OLC

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2024	
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
K 241	Continued From page 1 1. Observation on 5/14/24 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. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 241		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrier 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 REQUIREMENT 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 5/14/24 at 1:45 p.m. revealed	K 374		F

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
K 374	Continued From page 2 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.	K 374		

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - SOUTHWEST WING B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER avera mother joseph manor retirement community		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/14/24. Avera Mother Joseph Manor Retirement Community Building 2A was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

TITLE

(X6) DATE

Paula Henrickson, Administrator 05/31/2024

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

MAY 31 2024

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

PRINTED: 05/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 3A - NORTHWEST WING B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER avera mother joseph manor retirement community			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH 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) COMPLETION DATE	
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/14/24. Avera Mother Joseph Manor Retirement Community Building 3A, was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000			

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

TITLE

(X6) DATE

Paula Henrickson, Administrator 05/31/2024

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

MAY 31 2024

SD DCH-OLC

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER avera mother joseph manor retirement com		STREET ADDRESS, CITY, STATE, ZIP CODE 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 5/13/24 through 5/16/24. Avera Mother Joseph Manor Retirement Community was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/13/24 through 5/16/24. Avera Mother Joseph Manor Retirement Community was found in compliance.	S 000		

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

TITLE

(X6) DATE

Paula Henrickson, Administrator 05/31/2024