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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING _____ B. WING _____	C 06/04/2025

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

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/2/25 through 6/4/25. The areas surveyed were resident safety regarding elopement, resident neglect and an allegation of staff to resident abuse. Avera Mother Joseph Manor Retirement Community was found to have past non-compliance at F658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on South Dakota of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure professional standards of nursing practice were followed by licensed practical nurse (LPN) H who had failed to document and communicate one of one sampled resident (1) newly observed wound to the physician to initiate timely evaluation and treatment. Failure to document and communicate the new wound delayed wound treatment and may have delayed the healing of that wound. This citation is considered past non-compliance based on the review of the corrective actions the provider implemented immediately after they became aware of the wound and the provider's internal investigation. Findings include:	F 658	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Hemmelee | TITLE: administrator | (X6) DATE: 6/17/2025

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

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F 658	Continued From page 1 1. Review of the provider's 5/23/25 SD DOH FRI revealed: *On 5/22/25 resident [name] had been seen at a clinic appointment. *An ulceration to the dorsal aspect (back) of her left foot had been diagnosed and identified. *Treatment orders had been sent with resident 1 after her clinic appointment. *An order to apply optifoam (a type of wound dressing designated for advanced wound care) to be changed daily. 2. Review of resident 1's electronic medical record (EMR) revealed: *She had been admitted on 4/21/25 with diagnoses of a middle cerebral artery stroke on the right side of her brain that had affected the left side of her body and peripheral artery disease (narrowed blood vessels reduce blood flow to the limbs). *She had been receiving physical and occupational therapy. *Resident 1 had been able to eat independently required set up for oral hygiene. *She required moderate staff assistance with personal hygiene, and maximum assistance of staff with upper/lower dressing and mobility. *She was dependent on staff assistance with her footwear and bathing. *A skin risk assessment completed on 4/21/25 which indicated she was at risk for skin wounds. *Staff were to observe skin daily with all cares and report any changes to the charge nurse. 3. Interview on 6/3/25 at 8:50 a.m. with LPN G regarding new observed skin wounds revealed: *She would measure the wound and then document those measurements on the wound/incision complex flowsheet in the	F 658		

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F 658	Continued From page 2 resident's EMR. *The resident's wound measurements should also be documented on a paper communication sheet that was kept in a binder at the nurse's station. *She would have notified the resident's physician and family of the new skin wound. Information would have also been communicated to the nursing staff in a shift-to-shift report for their awareness. *She had recently received education on the provider's skin assessment/pressure injury prevention policy. 4. Interview on 6/3/25 at 9:10 a.m. with LPN J regarding new observed resident skin wound revealed: *She would have documented the resident's new skin wound in the physical assessment and then documented the measurements of the wound in the wound/incision complex flowsheet. *She would have also notified the resident's physician and family of the new skin wound. *If the skin alteration was from an unknown origin she would have completed a risk management form. *She would have documented the measurements of the wound in the resident's paper chart used to communicate the resident's wound healing. The paper chart had been kept in the nurse's station. 5. Interview on 6/3/25 at 10:10 a.m. with LPN F regarding a new observed resident skin wound revealed: *She would have measured the new skin wound and documented it in the wound/incision complex flowsheet in the resident's EMR. *She would have notified the resident's physician and family of the new skin wound.	F 658		

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F 658	Continued From page 3 *She would have reported the new skin wound in the nursing staff shift-to-shift report for their awareness. 6. Interview on 6/3/25 at 1:00 p.m. with LPN supervisor E regarding resident 1's left foot ulcer revealed: *LPN supervisor E had been unaware that resident 1 had an ulcer to her left foot, until she was notified by resident 1's nephew following the resident's clinic appointment on 5/22/25. *Once resident 1 had returned from her clinic appointment, LPN supervisor E measured the skin ulcer and documented the measurements in the resident's wound/incision complex flowsheet. *She notified resident 1's physician of the new skin ulcer on 5/22/25. *She had informed the charge nurse who had been caring for resident 1 of the new skin ulcer on 5/22/25. 7. Interview on 6/3/25 at 1:40 p.m. with LPN H regarding resident 1's left foot ulcer revealed: *She had been notified by certified nursing assistant (CNA) M on 5/18/25 of resident 1's newly observed skin wound. *LPN H assessed the skin wound and documented those measurements on her report sheet. *She thought she had documented the new skin wound in resident 1's EMR. -She confirmed there was no documentation of the resident's skin wound in the EMR. *She thought she had communicated the new skin wound in the nursing shift-to-shift report on 5/19/25. *LPN H had been unaware that new skin wounds needed to be documented in the wound/incision complex flowsheet in the resident's EMR.	F 658		

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F 658	Continued From page 4 *She had received additional education following that incident regarding the provider's skin assessment/pressure injury prevention policy,and required documentation. 8. Interview on 6/3/25 at 2:15 p.m. with CNA M regarding resident 1's new skin wound revealed: *She had assisted resident 1 with bathing and discovered the new skin wound on 5/18/25. *She had immediately notified LPN H on 5/18/25. *CNA M had asked resident 1 if she had been experiencing any pain, resident 1 denied any pain. *Resident 1 required the assistance of one to two staff members and the use of a gait belt to transfer due to her left-sided weakness. 9. Interview on 6/3/25 at 2:45 p.m. with LPN J regarding information she had received in the shift-to-shift report on the morning of 5/19/25 revealed she did not recall that she had heard resident 1 had a new skin wound to her left foot from LPN H. 10. Further review of resident 1's EMR revealed: *On 5/18/25 at 8:00 p.m. through 5/22/25 at 2:00 p.m. a physical assessment had been completed for resident 1 once per shift. -There was no documentation resident 1 had an alteration to her skin. *There was documentation resident 1 had her TED hose (stockings to help prevent blood clots to the legs) put on in the morning and removed at bedtime. 11. Interview on 6/3/25 at 3:15 p.m. with assistant director of nursing (ADON) C regarding the skin assessment portion of the resident physical assessment revealed:	F 658		

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F 658	Continued From page 5 *A head-to-toe skin assessment would have been completed weekly by a nurse. *She had agreed that if a nurse had documented normal skin condition on the physical assessment in the resident's EMR, the nurse assessed all of the areas of the resident's skin. 12. Interview on 6/3/25 at 3:30 p.m. with LPN I and LPN J regarding documentation of resident's skin on the physical assessment revealed: *The resident's skin that had been visible would have been assessed and documented in the skin assessment portion of the physical assessment. *A more thorough skin assessment would have been completed weekly on all residents. 13. Interview on 6/4/25 at 9:00 a.m. with CNA K regarding his documentation of putting on resident 1's TED hose on 5/19/25 revealed: *He had not observed any open areas to resident 1's feet that day. *If he had observed any new wounds in a resident skin, he would have notified the nurse immediately. 14. Interview on 6/4/25 at 10:00 a.m. with director of nursing (DON) B and ADON C regarding nurse assessments of resident's skin in the physical assessments revealed: *DON B had not expected nurses to complete a head-to-toe skin assessment on residents while completing the physical assessment. *Resident's skin would be assessed weekly by the nurse usually while the resident was bathed or if a new skin wound had been observed. 15. Interview on 6/4/25 at 2:45 p.m. with CNA L regarding her documentation of the removal of resident 1's TED hose on 5/20/25 revealed she	F 658		

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F 658	Continued From page 6 had not observed any open areas to resident's feet at that time. 16. Review of LPN H's department orientation checklist completed on her hire date of 5/12/25 revealed: *She had been validated for the completion of the following tasks: -Documentation of condition change of resident (observing, recording, and reporting). -Documentation of skin assessment/Braden Scale (an assessment tool used to identify resident's at risk for developing pressure ulcers) turn and reposition. 17. Review of the provider's May 2025 Skin Assessment/Pressure Injury Prevention policy revealed: *"A full head to toe skin assessment will be completed on admission and weekly for four weeks then quarterly thereafter or with change in status." *The physician will be notified of skin integrity issues/wound presence, if unrelated to admission, if unrelated to admission reason to long term care." 18. Review of the provider's June 2025 RN/LPN Orientation Program policy revealed: *"It is the policy of this facility that all newly hired RNs/LPNs Orientation Program. This program is competency based to assure quality care for residents. The program follows completion of general orientation." *"The RN/LPN must satisfactorily complete all areas of the RN/LPN Orientation Checklist prior to working independently in the facility." *"The main content areas included on the orientation checklist are:"	F 658		

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F 658	Continued From page 7 -"Policy/Regulation." -"Documentation." The provider's implemented actions to ensure the deficient practice does not recur confirmed on 6/4/25 after: record review revealed the facility had followed their quality assurance process, education was provided to all direct care staff regarding the documentation of new skin alterations, skin assessment/pressure injury prevention policy and followed residents' care plan, interviews related to staff understood the education that had been provided. Monitoring will be conducted to prevent the reoccurrence of a deficient practice. Based on the above information, non-compliance at F658 occurred on 5/18/25, and based on the provider's implemented corrective actions for the deficient practice confirmed on 5/27/25, the non-compliance is considered past non-compliance.	F 658		