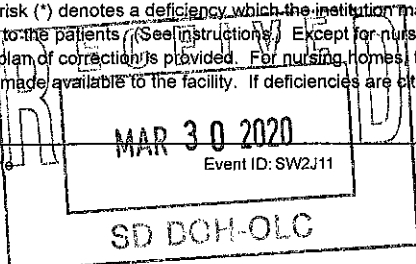
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437

(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 Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/10/20 through 3/12/20. Avera Eureka Health Care Center was found not in compliance with the following requirements: F554, F658, and F880.	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure consistency in assessment and implementation of self-administration of medication for six of nine sampled residents (4, 22, 29, 30, 40, and 46) Findings include: 1. Observation and interview on 3/11/20 at 9:45 a.m. with certified nursing assistant (CNA) A revealed: *A tube of Aspercreme in the tub room on a one drawer stand. The Aspercreme had a pharmacy label on it for resident 22. *She stated the CNAs applied the Aspercreme or a similar type of topical pain ointment on the residents for pain. She stated they had been instructed by the nurses to apply those medications. Review of resident 22's medical record revealed:	F 554	Self-administration of Medication policy will be reviewed with all nursing staff including licensed nurses and CNAs at a mandatory meeting on 3/30/2020. Education will include review of policy and professional standards of nursing, scope and practice of CNA and their role/responsibility for residents and self-administration of medication; specifically that application of medication must involve a licensed nurse. Throughout the week of 3/16/2020, an RN went through the list of residents, including residents 4, 22, 29, 30, 40 and 46, with current orders to keep medicated creams at bedside and updated orders and care plans as appropriate to reflect which residents are capable of applying medicated creams themselves and which residents require assistance from a licensed nurse. Licensed nurses are now applying medicated creams in accordance with professional standards. Per policy, an assessment of the resident's ability to self-administer medication will be performed by the IDT every three months, based on changes in the resident's medical and decision making status, and as needed. The "Self Administration LTC" intervention will be completed quarterly in Meditech by a licensed nurse to assess resident's medical decision making status for self administration of medications. Director of Nursing or delegated RN will complted an audit of "Self Administration LTC" intervention and will assess for appropriate application of medicated creams weekly for 6 months beginning the week of 3/30/2020 to ensure compliance with Self-Administration of Medication policy. Continued....	4/10/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Weber
TITLE: Administrator
(X6) DATE: 3/27/20

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 554	Continued From page 1 *A 3/26/18 physician's order for Aspercreme. Apply to affected areas twice daily for pain. *There was no physician's order received for her to have self-administered the Aspercreme. *There were no self-administration of medications assessments. *Her 8/16/19 last reviewed care plan revealed pain interventions that included: "Administer Tylenol 650 mg [milligram] bid [twice daily] and prn [as needed] and aspercreme bid as ordered (nurse)." 2. Observation on 3/11/20 at 10:00 a.m. in resident 46's room revealed a tube of Aspercreme in her bathroom. Review of resident 46's medical record revealed: *A 9/6/18 physician's order for Aspercreme to apply to both knees as needed. Could be kept at bedside. *She had a 2/24/20 self-administration of medication assessment. That assessment revealed "[resident name] requires assistance with the adminstration of her meds [medication] for the safety of both [resident name] and others around her R/T [related to] her cognitive impairment AEB [as evidenced by] BIMS [Brief Interview of Mental Status] score of 0 [zero] and Dx. [diagnosis] of dementia." *Review of her 2/27/20 care plan under her pain assessment interventions revealed, "May administer Aspercreme PRN for bilateral knee discomfort." 3. Interview on 3/11/20 at 10:30 a.m. with CNA A revealed she stated quite a few of the residents had the above medication in their rooms for the CNAs to apply.	F 554	Director of Nursing will report findings of audits to the Quality Assurance Performance Improvement Committee quarterly for 6 months	

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F 554	Continued From page 2 Interview on 3/11/20 at 10:45 a.m. with registered nurse (RN) E revealed the nurses should have applied those ointments. She was not aware the CNAs had been applying those medications. 4. Observation on 3/11/20 at 3:15 p.m. of resident 30's bathroom revealed a tube of muscle rub cream in her bathroom. Review of resident 30's medical record revealed: *A 10/9/19 physician's order "DC [discontinue Aspercreme when gone - ctn [continue] Muscle Rub Cream affected areas PRN. (May keep in room)." *A self-administration of medications assessment on 9/11/18 revealed she had been able to self-administer medications. On 2/27/19 it stated no. Monthly checks had been done but it was not clear which medications were checked 10/9/19. *A 1/27/20 self-administration of medications assessment revealed "[Resident name] requires assistance with administration of all her meds for the safety of both [resident name] and others around her due her physical functional limitations of her shoulders." *Review of her 1/28/20 last reviewed care plan revealed a 9/11/18 self-administration intervention: "[Resident name] is not able to administer her medications safely due to limited function to her upper extremities. The nurse administers them to her." 5. Observation and interview on 3/11/20 at 3:30 p.m. with resident 40 revealed she had a tube of Aspercreme ointment in a drawer under her television. She stated she had the CNAs apply it to her legs.	F 554		

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F 554	Continued From page 3 Review of resident 40's medical record revealed: *A 8/29/15 physician's order for Aspercreme "May keep at bedside and apply to skin topically as needed." *Her self-administration assessment after set-up on 2/17/20 revealed: "[Resident name] is alert and physically able to self-administer her own meds after set-up in regards to the safety of both [resident name] and others around her." It did not address her ability to self-administer her topical medications. *Review of resident 40's 2/20/20 last reviewed care plan revealed a 2/14/16 intervention for the self-administration of medications. "May administer own meds after set up assist." 6. Observation and interview on 3/11/20 at 4:00 p.m with resident 29's husband revealed: *A tube of Aspercreme ointment was in her bedside table. *Resident 29's husband stated the CNAs applied that when they assisted her in the morning. Review of resident 29's medical record revealed: *She had no physician's order for the self-administration of medications. *A self-administration of medication after set-up assessment on 1/27/20 stated she required total assistance with her medications. 7. Observation on 3/11/20 at 4:15 p.m. of resident 4's room revealed a tube of Aspercreme in her room. Review of resident 4's medical record revealed: *A 9/25/19 physician's order: "[Resident name] may administer her medications safely after setup with harm to other residents." *There was no order for her to keep any	F 554		

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F 554	Continued From page 4 medications in her room to self-administer. *A 12/16/19 self-medication administration after set-up assessment revealed "[Resident name] is alert and physically able to self-administer her meds after set-up - nursing staff report that she takes her meds as they are given to her." *Review of her 12/17/19 last revised care plan revealed no information on the self-adminstration of Aspercreme and her keeping it in her room. 8. Interview on 3/12/20 at 9:30 a.m. with director of nursing F revealed: *A self-administration of medications comprehensive assessment was completed on admission in the electronic medical record (EMR). *Then every quarter she completed a hand written assessment. *That assessment did not include all the same questions as the assessment on the EMR and usually only addressed oral medications. *She was not aware the CNAs had been applying the Aspercreme. *She did state the above residents had a physician's order for having the medication at bedside. *She did not know that was only if the resident was able to self-administer which included topicals. Review of the provider's last revised November 2018 Self-Administration of Medication policy revealed: *"An assessment of the residents' ability to self-administer medication will be performed by the IDT [interdisciplinary team] every three months, based on changes in the residents' medical decision-making status, and as needed," *"A physician's order will be obtained and	F 554		

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F 554	Continued From page 5 recorded in the chart. The order also will include which specific medications can be kept at the bedside."	F 554	Self-Administration of Medication policy will be reviewed with all nursing staff including licensed nurses and CNAs at a mandatory meeting on 3/30/2020. Education will include review of policy and professional standards of nursing, scope and practice of CNA and their role/responsibility for residents and self-administration of medication; specifically that application of medication must involve a licensed nurse. Throughout the week of 3/16/2020, and RN went through the list of residents, including residents 4,22, 29, 30, 40 and 46, with current orders to keep medicated creams at bedside and updated orders and care plans as appropriate to reflect which residents are capable of applying medicated creams themselves and which residents require assistance from a licensed nurse. Licensed nurses are now applying medicated creams in accordance with professional standards.Per policy, an assessment of the resident's ability to self-administer medication will be performed by the IDT every three months, based on changes in the residents' medical and decision making status, and as needed. The "Self Administration LTC" intervention will be completed quarterly in Meditech by a licensed nurse to assess residents' medical decision making status for self-administration of medications.	4/10/2020
F 658 SS=E	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: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate processes were in place for the delegation of medication administration by certified nursing assistants (CNA) for six of nine sampled residents (4, 22, 29, 30, 40, and 46). Findings include: 1. Observation and interviews revealed CNAs had been administering a topical physician ordered medication. Medication administration was not included in the CNAs scope of practice. Refer to F554.	F 658		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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.	F 880	Director of Nursing or delegated RN will complete an audit of "Self Administration LTC" intervention and will assess for appropriate application of medicated creams weekly for 6 months beginning the week of 3/30/2020 to ensure compliance with Self-Administration of Medication policy. Director of Nursing will report findings of audits to Quality Assurance Performance Improvement Committee quarterly for 6 months.	

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F 880	Continued From page 6 §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 §483.70(e) 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	F 880	Administrator, Director of Nursing and IDT in collaboration with the Medical Director have reviewed policy and procedures about hand hygiene, glove use and maintaining multiple resident use items in a sanitary manner as of 3/27/2020. Infection Control education and training will be completed on 3/30/2020 at a mandatory meeting for all departments with review of policy and procedures about hand hygiene, glove use and maintaining multiple resident use items in a sanitary manner. Proper hand hygiene and glove use will be demonstrated by Director of Nursing and a RN with return demonstration required of all employees at that time. All staff will be educated about their role and responsibility for infection prevention and control. Mechanical lifts will be sanitized between each resident use and will receive education and training on this during the 3/30/2020 mandatory meeting. Director of Nursing or other delegated nurse/leader will complete a weekly audit for 6 months of hand hygiene, glove use and sanitization of mechanical lifts to ensure proper policy/procedure. During audits, education will be provided on the spot if/when an employee is observed using incorrect procedure for the listed tasks. Audit tool will be utilized for hand hygiene and sanitization of lifts between residents. Director of Nursing will report findings of the audits to the Quality Assurance Peformance Improvement Committee quarterly for 6 months.	4/10/2020

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F 880	Continued From page 7 contact with 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: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Appropriate hand hygiene and glove use during two of four sampled residents (19 and 40) personal care by four of five certified nurse assistants (CNA) (C, D, H, and I) was used. *Mechanical lifts had been sanitized by three of three CNAs (D, H, and I) between residents' use during two of two observations. *Appropriate hand hygiene and glove use during one of two sampled resident (47) dressing changes by one of two nurses (E) was done. Findings include: 1. Observation on 3/10/20 at 8:45 a.m. revealed: *CNA C entered resident 19's room and put on gloves. She had not completed any hand hygiene. *With those same gloves she retrieved the	F 880		

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F 880	Continued From page 8 resident's clothes from her closet, raised the bed, put lotion on both of the resident's legs, put on her support stockings, and her shoes. *Put on new gloves and without performing any hand hygiene she assisted the resident with washing her face, hands, and back. *Removed her gloves and used hand sanitizer then retrieved a standing lift from the hallway. *Entered the room with the lift and put on gloves. *CNA C and CNA D assisted the resident to a standing position with the lift. *Moved the resident into the bathroom with the lift, and CNA C removed the resident's incontinence brief. She removed her gloves and did not perform any hand hygiene. *After resident 19 had finished on the toilet CNA D provided perineal care. She used the same disposable wipes to clean from front to back twice and then used a second cloth in the same way. *When they had put resident 19 in her wheelchair CNA D removed the standing lift from the room and took it into another resident's room. *She had not sanitized her hands or the standing lift. Review of resident 19's 1/8/20 care plan revealed: *A goal to be free from infections through the next target date. *A intervention: "History: Noted a discharge diagnosis of UTI [urinary tract infection] and CRE [carbapenem resistant] bacteria carrier during recent hospitalization upon return on 1/2/20." Interview on 3/12/20 at 9:30 a.m. with director of nursing (DON) F revealed: *CNAs C and D had not followed proper handwashing and glove use. *She monitored handwashing and glove use on a	F 880		

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F 880	Continued From page 9 regular basis. *She was aware resident 19 had been classified as a CRE bacteria carrier. *Staff had not been instructed on any enhanced precautions. Surveyor: 41895 2. Observation and interview on 3/11/20 at 9:28 a.m. of registered nurse (RN) E with resident 47 during a dressing change revealed: *She cleaned the wound. *Then she removed her soiled gloves. *She had new clean gloves on the barrier with her dressing supplies and when she had reached for them one glove had fallen into the contaminated sink. -She picked up the glove and put both the gloves on. *She did not perform hand hygiene between changing her gloves. *After the dressing change was completed she removed her gloves and washed her hands at the sink. -She did not wash her hands for twenty seconds. *She had agreed she should have washed her hands between glove use. *She had not noticed her clean glove had fallen into the sink. *Agreed her hand washing time was not long enough. 3. Observation and interview on 3/10/20 at 2:53 p.m. of CNAs H and I assisting resident 40 revealed: *Both CNAs had clean gloves on and were assisting the resident to change a soiled incontinence brief in bed.	F 880		

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F 880	Continued From page 10 *CNA I had performed perineal (peri) care, and then with those same contaminated gloves on she: -Had applied protective ointment to the resident's bottom. -Assisted the resident into a new incontinence brief. -Pulled up her pants. *CNA I then changed her contaminated gloves with no hand hygiene in between. *CNA H had assisted CNA I with rolling the resident back and forth in the bed to complete the task then removed her gloves. -She did not perform hand hygiene after removal of those contaminated gloves. *Then they put the Hoyer sling under her. *After CNA I removed her contaminated gloves, and did not perform hand hygiene she grabbed the mechanical lift. *Both CNAs assisted to hook the resident in the Hoyer sling to the mechanical lift and put her into her wheelchair (w/c). *CNA H had taken candy out of drawer, given it to the resident, and then proceeded to comb her hair. -She still had not performed hand hygiene. *CNA I pushed the mechanical lift out of the room and left it in the hallway, then she took the garbage to the dirty utility room, and then performed hand hygiene when she was back in the hall. *CNA H assisted the resident in her w/c down the hall to an activity, and then stopped to perform hand hygiene. *Both CNAs agreed: -They should have performed hand hygiene each time they removed their gloves and before leaving the resident's room. -The mechanical lift could be contaminated due	F 880		

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F 880	Continued From page 11 to them not performing hand hygiene. *CNA I thought the night shift cleaned the lifts. *CNA H said she would have cleaned the mechanical lift if it was visibly soiled otherwise housekeeping cleaned them. Interview on 3/11/20 at 8:14 a.m. with housekeeping manager J revealed: *Housekeeping did not clean the mechanical lifts. *Nursing was responsible to clean the mechanical lifts. Interview on 3/12/20 at 10:40 a.m. with DON F about the above observations revealed: *She agreed staff should have washed their hands with each glove change and before leaving a resident's room after care. *She agreed the mechanical lift should have been cleaned. *The night shift CNAs had a cleaning schedule, and the mechanical lifts were on the schedule. *The CNAs had been educated to use the sanitizer wipes on the mechanical lifts after use if it had become contaminated. *The housekeepers did not clean the mechanical lifts. Surveyor: 26632 4. Review of the provider's last reviewed March 2020 Hand Hygiene policy revealed: *Wash hands with soap when visibly dirty, contaminated with blood or body fluids. *To use friction for twenty seconds. *Change gloves when moving from a contaminated area to a clean area of care. *Always wash hands or use alcohol cleaner after the removal of gloves. Review of the provider's last reviewed January	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. BUILDING ______ B. WING ______	**03/12/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 2020 Disinfection of Non-Critical Patient (resident) Care Equipment policy revealed: *Non-critical resident care items between/after each resident use. *They require low level disinfection by cleaning periodically with a disinfectant, detergent, or germicide.	F 880		

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

PRINTED: 03/20/2020
FORM APPROVED
OMB NO. 0938-0391

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	435078	A. BUILDING ______ B. WING ______	03/12/2020

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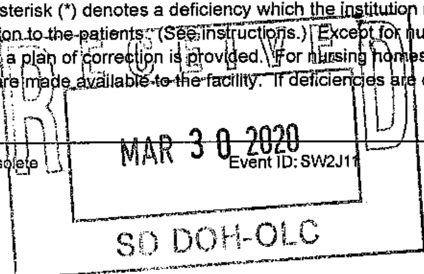
E 000	Initial Comments Surveyor: 32332 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 3/10/20 through 3/12/20. Avera Eureka Health Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carmen Weber	Administrator	3/23/20

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**03/10/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	**202 J AVENUE POST OFFICE BOX 40** **EUREKA, SD 57437**

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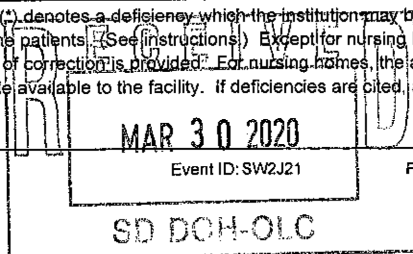
K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/10/20. Avera Eureka Health Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K371 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 371 SS=D	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain a corridor separation from staff use areas at one of two smoke separations (west wing) in two of four smoke (west wing and center area) compartments. Findings include:	K 371	Plant Operations Manager sealed both penetrations located at the west wing smoke separation doors with LCI Intumescent firestop sealeant. Plant Operations Manager will report to the Quality Assurance Performance Improvement Committee at their next meeting in April that these penetrations were sealed.	3/24/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Weber
TITLE: Administrator
(X6) DATE: 3/24/20

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. BUILDING **01 - MAIN BUILDING 01** B. WING	03/10/2020

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K 371	Continued From page 1 1. Observation on 3/10/20 beginning at 12:15 p.m. revealed the west wing smoke separation doors had two penetrations. Each was two inches in diameter and were not smoke tight. Both of the penetrations were for low voltage wiring. Interview with the director of plant operations at the time of the observations confirmed that finding. He stated the contractors were difficult to manage in smoke barrier integrity. The deficiency affected two smoke compartment locations required to maintain smoke separation.	K 371		

South Dakota Department of Health

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	10618	A. BUILDING: ___ B. WING ___	03/12/2020

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S 000	Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/10/20 through 3/12/20. Avera Eureka Health Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/10/20 through 3/12/20. Avera Eureka Health Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carmen Weber	Administrator	3/23/20