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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/10/25 through 2/13/25. Avera Eureka Health Care Center was found not in compliance with the following requirements: F689, F692, F761, F812 and F880.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure the proper storage of hazardous products and sharp objects to prevent resident accidents in one of one observed facility beauty shop. Findings include: 1. Observation on 2/11/25 at 9:35 a.m. in the facility beauty shop revealed: *The door was open and no facility or beauty shop personnel were present. *There was a countertop vanity sink with two cupboards and two drawers where beauty shop products and supplies were stored. *There were 12 beauty shop products with printed warning labels on the containers. *Disinfectant Sani-wipes were stored on the	F 689	A keypad lock was installed on the Beauty Shop door on 2/14/25. A sign has been posted by the door that states, "the code is the current year", so that staff, beauticians or cognitive residents can get into the beauty shop when needed for hair appointments or to use the phone. Facility wide education provided to all staff at a meeting on 3/13/25 that the beauty shop door is to be shut at all times unless being used by the beautician or a resident is using the phone. Administrator will monitor the door 2 times per week for 6 weeks then weekly for 6 weeks to make sure the door is shut when the room is not in use. Administrator will report the results to the Quality Assurance Peformance Improvement Committee quarterly for 6 months.	3/13/25

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

Carmen Weber

TITLE
Administrator

(X6) DATE
3/7/25

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 _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 689	Continued From page 1 countertop. -The container label read "Keep Out of Reach of Children." *Bed Head hairspray was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children" and "Avoid Contact With Eyes." *Fanci Full instant hair color (liquid) was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children", "Flammable", "May Cause Eye and Skin Irritation", and "For External Use Only." *Biolage shampoo was was stored in one of the cupboards. -The container label read "For External Use Only", "Keep Out of Reach of Children", and "Avoid Contact With Eyes." *Biolage conditioner was stored in one of the cupboards. -The container label read "For External Use Only", "Keep Out of Reach of Children", and "Avoid Contact With Eyes." *Fanci Full instant color mousse was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children", "Danger", "Flammable", "May Cause Eye and Skin Irritation", and "For External Use Only." *Acetone nail polish remover was stored in one of the cupboards. -The container label read "Danger", "Extremely Flammable Liquid and Vapor", "Causes Serious Eye Irritation", "Keep Away From Heat, Sparks, Open Flames, and Hot Surfaces." *Head and Shoulders shampoo was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children." *Rave 24 Hour extreme hold hairspray was	F 689		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 689	Continued From page 2 stored in one of the cupboards. -The container label read "Keep Out of Reach of Children", "Danger", "Flammable", "Avoid Inhalation", and "Avoid Contact With Eyes." *Vidal Sassoon mousse was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children", and "Avoid Contact With Eyes." *Fanci Full color mousse white mix was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children", "Danger", "Flammable", "May Cause Eye and Skin Irritation", and "For External Use Only." *Suave hairspray was labeled was stored in one of the cupboards. -The container label read "Keep Out of Reach of Children." *An electric blow dryer stored in one of the cupboards with the labeled products. *The cupboard that contained those hazardous products was unsecured and accessible to the residents. *In one of two sink vanity drawers there were four white containers that stored beauty supplies. - One container had two pairs of cutting scissors stored on top of the opened scissor case. *That drawer was unsecured and the scissors were accessible to the residents. 2. Observation on 2/10/25 in the resident dining room between 4:50 p.m. and 5:10 p.m. revealed: *Resident 13 had locomoted herself down the hallway and stopped at the beauty shop door and looked inside. -Staff personnel re-directed resident to the dining room for the evening meal. 3. Interview on 2/12/25 at 4:12 p.m. with director	F 689		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 689	Continued From page 3 of nursing (DON) B regarding the beauty shop revealed: *She explained the beauty shop door was left open because it was located where the staff could easily access the phone and use it. -The beauty shop was located across the hall from the resident dining room. -The beauty personnel brought and stored their beauty products and supplies in the beauty shop. -She was unsure of who was responsible for cleaning, maintaining, and ensuring the proper storage of the beauty shop products and supplies and stated "Maybe the activities department." -The activities director was out of the facility on 2/12/25 and unavailable for an interview. 4. Review of the providers 04/2023 "Storage Areas" policy revealed: *The providers policy defined storage procedures for the environmental services (housekeeping and laundry) departments. -"These areas are to be maintained in a clean and safe manner." -"Flammable liquids, combustible gases, etc., should not be stored in these areas where intense heat or open flame devices could ignite such matter." -"Cleaning supplies, etc., shall be stored in areas separate from food storage rooms and shall be stored as instructed on the labels of such products." *No policy was provided on the proper storage of hazardous products for the facility beauty shop or for any resident environment areas.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 4 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to thoroughly assess for nutritional needs that included use of built up silverware, consistently implement, monitor, make care intervention revisions, notify the physician timely of unplanned weight loss; and ensure licensed nursing staff were aware of the reweigh policy and physician notification policy and all licensed nursing and dietary staff were aware of the enhanced food program for one of one sampled resident (43) at nutritional risk and with significant weight loss. Findings include: 1. Observation on 2/10/25 at 5:08 p.m. of resident 43 in the dining room revealed: *He propelled his wheelchair into the dining room	F 692	Collaboration occurred between Administrator, Director of Nursing, Registered Dietician, Dietary Manager and Medical Director to review current policy and procedure related to resident nutritional status, residents who require assistance and interventions who are at nutritional risk, timely weight loss notifications and proper documentation that notification has been completed, oral supplements, enhanced menu items, use of built up dining utensils, prompting/ physical assistance for residents and prompt meal service. Resident 43 had been assessed upon admission to the facility on 7/30/24 by Occupational Therapy and received Occupational Therapy from 7/30/24 through 10/7/24. During that time frame, no recommendations were made for adaptive eating devices. On 2/13/25 Registered Nurse on duty completed a bedside swallow evaluation after surveyor relayed she observed coughing; bedside swallowing screen result was negative and residents did not have any signs of aspiration during the screening. Occupational therapy was consulted to re-evaluate resident 43 and evaluation was completed on 2/17/25. During the evaluation, resident 43 exhibited behaviors which included continued...	3/13/25

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 5 by using his feet. *He was thin and had loose skin on his arms. 2. Observations on 2/11/25 at 11:05 a.m. of resident 43 in the dining room revealed: *At 11:05 a.m. he was eating his dessert and spilled some of it on the table. -He bent his head down and licked the dessert from the table. *At 11:07 a.m. he left the dining room before the remainder of his meal was brought to him. -At 11:08 a.m. a staff member returned him to the dining room, and his meal was brought to him. *A portion of his meal was a piece of sausage with a casing around it. -When he attempted to cut the sausage with a knife and fork, his plate slid back and forth on the table. -He placed the knife and fork on the table and pushed the plate across the table away from himself. -A few minutes later he pulled the plate towards himself and started to eat with his fingers. *He then picked up his knife and fork. They slipped from his hands, and fell on the floor. *He again pushed the plate of food across the table. *A staff member picked up the silverware from the floor, asked him if he was done eating, and then brought him clean silverware. *He thanked the staff member for the silverware, drank some water and started coughing. *The staff member did not assist him with bringing the plate back to his side of the table. *He then left the dining room without finishing his meal. *He had eaten the sausage, approximately 50 percent of his dessert, and two-thirds of a glass of water. There were no other fluids provided to	F 692	yelling to remove the food, throwing items on the floor and at the occupational therapist, attempts to push the food tray onto the floor and attempts to throw silverware. Occupational therapist assessed for the need to use adaptive silverware and made this recommendation, "Upon evaluation and throughout this session this date, [patient] does not appear to have any fine motor deficits or difficulty with dexterity. [Patient] was able to reach and grab items that he wished for and push away items. It is felt that [patient] would be a danger to self and others if too many adaptations were given to [patient] as it is in his mind if he wants to eat or not. Many options of food were given to [patient], but he was not interested in any of these options." Director of Nursing verified with dietary department that all diet cards are correct with current interventions to ensure that resident is being offered adequate nutrition and hydration and also that resident is offered meals and snacks whether he accepts or refuses. Director of Nursing did verify with dietary and nursing staff that there has not been a period of time where resident was not offered meals. Large-handled silverware (spoon and fork) offered continued...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 6 him to drink. 3. Observation on 2/12/25 at 4:39 p.m. of the dining room revealed: *Resident 43 was not in the dining room. -His place at the table had a glass of orange juice, a bowl of peaches, and plastic container of orange Sherbet. 4. Observation and interview on 2/13/25 at 8:16 a.m. with resident 43 revealed: *He was in the dining room, seated at a table, with a clothing protector on. -No drinks or food were at his place at the table. -He stated the food "is alright". 5. Observation on 2/13/25 at 8:20 a.m. of resident 43's place in the dining room revealed: *He was not at the table. *A glass of orange juice, toast, an egg, a banana, and a bowl of Cheerios was at his place at the table.. -No other drinks had been provided with his meal. 6. Review of resident 43's electronic medical record (EMR) revealed: *He was admitted on 7/30/24. *His Brief Interview of Mental Status (BIMS) assessment score was a 10, which indicated he had mild cognitive impairment. *His diagnoses included: Dupuytren's contracture (a condition that causes the fingers to curl and become permanently bent) in both of his hands, anorexia, chronic kidney disease, diabetes, and Alzheimer's Dementia. *On 7/28/24 his hospital record provided to the facility indicated that occupational therapy (OT) was to evaluate his need for adaptive silverware. *His 7/30/24 admission orders included: "Pt	F 692	for resident with all meals as an option to use as he desires. Care plan for resident 43 was updated on 3/3/25 to reflect current interventions as noted above for weight loss. Director of Nursing, Dietary Manager and Dietician will review weight report weekly for 6 months beginning the week of 3/10/25 to ensure that any weight changes are addressed and to ensure that interventions are implemented and communicated to all necessary team members and care planned appropriately. Education will be provided at all staff meeting on 3/13/25 on Weight and Weight Changes policy and Change in Resident's Condition or Status policy review including topics related to resident nutritional status, residents who require assistance and interventions who are at nutritional risk, timely weight loss notifications and proper documentation that notification has been completed, oral supplements, enhanced menu items, use of built up dining utensils, prompting/ physical assistance for residents and prompt menu service. Beginning 3/10/25, audits will be completed by the Director of Nursing or designated licensed nurse weekly for 4 weeks to ensure continued...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 7 [patient] would benefit from PT [physical therapy]/OT". Review of resident 43's 2/12/25 care plan revealed: *He was independent with eating. -Staff were to provide setup assistance or assistance of one staff member with eating as needed. *His nutritional status focus area included: he had weakness of right shoulder, Dupuytren's contracture to both hands, diabetes, chronic kidney disease, and "Functional limitations noted to UE [Upper Extremity]". -The outcome for that focus area included his "weight will remain between 130 lbs [pounds] - 140 lbs." -His nutrition interventions included: --Carbohydrate Consistent Diet. --"Apple juice, orange juice, and a banana with all meals." --Resident 43 "is provided 3 meals and Siesta and HS [hour of sleep] snacks during nutrition pass daily, takes ice cream with boost [supplement] PRN [as needed] at HS snack". Review of resident 43's documented weights record revealed: *On 8/20/24 he weighed 134 pounds (lbs) and 8 ounces (oz). *On 9/24/24 he weighed 133 lbs. and 8 oz. *On 10/22/24 he weighed 127 lbs. and 5 oz. *On 11/19/24 he weighed 128 lbs. and 8 oz. *On 12/3/24 he weighed 125 lbs. *On 12/10/24 he weighed 121 lbs. *On 12/17/24 he refused to be weighed. *On 12/24/24 he weighed 119 lbs. and 8 oz. -That was a weight loss of 7 percent from 11/19/24 to 12/24/24 and considered a significant	F 692	compliance with documentation and weight change notification. After 4 weeks of weekly audits demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit results will be reported quarterly to the Quality Assurance Peformance Improvement Committee by Director of Nursing, Administrator or designated Quality Assurance nurse until the facility demonstrates sustained compliance determined by the committee.	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 8 weight loss. *On 12/31/24 he weighed 117 lbs. *On 1/7/25 he weighed 117 lbs. Review of resident 43's registered dietitian (RD) nutrition notes revealed: *On 8/7/24 his admission nutrition assessment was completed by the RD and indicated: -He had unplanned weight loss in 2024. -Was hospitalized on 7/25/24 after a fall at home. -His diagnoses included: urinary tract infection, dehydration, weakness, chronic kidney disease, and diabetes. -He had bilateral hand contractures. -His weight was 134 lbs 5 oz. which was down from 148 lbs in July (2024). -His diet was a constant carbohydrate diet, he had no eating problems documented, and his own teeth were in "good repair". *On 1/10/25 the RD note indicated: "Alerted to resident's unplanned weight loss in [the] past month. Weight declined from 138-147 [lbs] per variety of scales at July admission to near 130 lbs in Oct/Nov. December weight declined current 117 [lbs.]- no eating dental problems 57% nursing intake records. he notified [medical doctor name] [on] 1/8/25 documentation that he had no appetite and she recommended adding daily chocolate BOOST supplement added Enhanced Food Program and daily Glucose Control BOOST at meals. Will review weight monthly. resident at risk for malnutrition." *On 2/5/25 the RD note indicated: "nutrition status is moderately compromised with unplanned weight loss in 2024. Weight improved to 119 lbs from 117 lbs on 2/4/25 Some refusal of supplements. Mirtazapine [an antidepressant that my increase appetite] ordered 1/23/25. "	F 692		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 9	F 692		

Review of resident 43's physician progress notes revealed:
*On 1/8/25 the note indicated, "Due to his weight loss, he was encourage to participate in all meals and will be started on chocolate boost."
*"Patient had significant weight loss with weight down to 117 pounds. He says he just has no appetite."
*On 1/23/25 the note indicated, "Patient continues to have anorexia and slightly depressed mood. He was started on supplemental nutrition and has gained 2 pounds with weight still low at 117 pounds. We will begin mirtazapine 15 mg [milligrams] nightly to see if this will help improve his appetite."

Review of resident 43's nurses notes revealed:
*On 1/7/25 "Resident needs reminders to come out for meals. He does come out at times and then will go back to his room because he doesn't wait. Resident does eat well when he comes out. Reminders given at all meals to come out to eat."
*On 2/6/25 "Resident refusing to eat all day. Would come out for meals but then go back to his room. He will yell out if you try to get him to stay in the dining room to eat."

7. Record review and Interview on 2/12/25 at 3:53 p.m. with director of nursing B regarding resident 43's weight loss revealed:
*She confirmed his 7/28/24 hospital discharge summary included the hospital's RD had recommended an OT consultation for adaptive eating devices, "OT consult was ordered".
-She stated an OT consultation was not completed as there was no occupational therapist available to complete the assessment.
*Resident 43 was an avid organic farmer, and they had tried interventions of fresh fruits and

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 10 vegetables. *When he did not come to the dining room for meals, they had attempted meal tray service in his room. -They had not provided meal tray service in his room since he had dumped his soup in the trashcan. 8. Interview on 2/13/25 at 8:31 a.m. with certified nursing assistant (CNA) R regarding obtaining residents weight revealed: *CNA's would weigh the residents. -If a resident had more than a three pounds weight loss, she would notify the nurse. -The nurse would decide what to do with that information. 9. Interview on 02/13/25 09:29 AM with registered nurse (RN) E regarding weighing of residents revealed: *All residents were to be weighed weekly, after their bath. -If a resident refused a bath, they were to have a bath within a week and would be weighed at that time. *If a resident had more than a five pound weight loss, the CNA was to reweigh them, or the nurse was to ask the CNA to reweigh them. -The second weight would not be recorded if it was the same as the first weight taken. *Resident 43 was to be weighed on a weekly basis. -She felt his weight had "dropped steadily" over time. *The provider had an enhanced food program that included the addition of fats and other items to food to increase the calories. -She was not sure if resident 43 was on an enhanced food program.	F 692		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 11 *Weight loss would be reviewed during residents' care conferences, and the interdisciplinary team (IDT) would discuss what would be best for the resident with the weight loss. *The RD reviewed and made recommendations related to residents with weight loss and the IDT would follow those recommendations. 10. Follow-up interview on 2/13/25 at 10:14 a.m. with RN E regarding physician notification of a resident's weight loss revealed: *They should have a process of who was to notify the physician of a resident's weight loss related to refusals to eat. -She was not certain who would have been responsible for notifying the physician of resident 43's weight loss. -The weight loss notification was "probably done on rounds" (when the physician routinely reviews the resident's condition and their medical needs). *If a resident's weight loss may be related to a cardiac issue the nurse would notify the physician immediately. 11. Interview and review of resident 43's diet card on 02/13/25 at 9:34 a.m. with cook G revealed: *Resident 43 was diabetic, and his physician ordered diet was "Carbohydrate Consistent Diet". *The areas for adaptive and feeding ability were blank. *He was to be offered a banana at every meal. -She just "knows" this; it was not on his diet card. *He was not receiving dietary supplements due to his refusals of them. *He was offered bananas and oranges, at times, as he would eat them. *She was not certain if he was on an enhanced food program. -She stated the enhanced food program included	F 692		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 12 serving the resident foods with extra butter on vegetables, and extra cheese, milk, whipped toppings, and potatoes. -The current enhanced food program resident listing located in the kitchen did not include resident 43. 12. Interview on 2/13/25 at 10:38 a.m. with administrator A regarding resident weight loss revealed she: *Would have expected someone to assist resident 43 with cutting up his food. *Confirmed resident 43 had lost nine pounds between November and December that was a significant weight loss. *Confirmed the occupational therapist was not available to complete an OT evaluation for resident 43's need for adaptive silverware. *Stated the physician was only available for two half days each week. -A message would be left for the physician and the physician would enter a note in the resident's EMR when she received the message. *Would have expected the provider's policies to be followed by the staff. 13. Review of provider's 9/24 revised Weight and Weight Changes policy revealed: *"Significant weight changes will be monitored by the LTC Weight Report and will be addressed by the Dietitian and Nutritional Risk Team. The Nutritional Risk Team will consist of the Dietitian, Dietary Manager, Resident Care Coordinator (s) Safety/Quality, IDT members that assist with feeding Residents and the Director of Nursing." *"Each resident will be weighed at least monthly or more frequently (weekly or daily) per physician's order, nursing or dietitian recommendation."	F 692		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 13 *"Re-weight will be obtained if there is a weight change of 3 pounds or greater from prior weight. Re-weight will occur the next day." *"Significant Interval % of Weight Change -1 month 5% -3 months 7.5% -6 months 10%" *"The LTC Weight Report will be run weekly. The dietitian and Resident Care Coordinator will reassess residents with a significant weight change. Appropriate recommendations will be documented in the medical record and Care Plan Updated." *"Residents with significant weight change should be monitored by the Nutritional Risk Team, for Nutrition Risk." *"Reweigh resident the next day if there is a 3# weight difference (greater or less) than prior weight." *"In the event of significant weight loss, the resident's physician shall be notified by the Nurse or Resident Care Coordinator." *"Review dining room seating and environment. Identify if resident needs increased assistance at meals. Contact Occupational therapy if needed." *"Offer supplements or nourishments between meals." 14. Review of the provider's July 2023 Change in a Resident's Condition or Status policy revealed: *"Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status." *"The Charge Nurse will notify the resident's attending physician when:" -"There is a significant change in the resident's physical, mental or psychosocial status". -"There is a need to alter the resident's treatment	F 692		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 692	Continued From page 14 significantly". -"Deemed necessary or appropriate in the best interest of the resident". *"The Charge Nurse will record in the resident's medical record any changes in the resident's medical condition or status."	F 692		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to establish	F 761	Review and revision of policy/ procedure occurred between Administrator, Director of Nursing and pharmcy consultant during the weeks of 2/17/25 through 3/3/25 to ensure that all controlled medications whether scheduled or PRN are appropriately secured, stored, accurately reconciled and disposed of. Beginning on 3/3/25, a Controlled Substance Log was put into use for the scheduled controlled substances. All scheduled controlled substances are locked behind two locks on the medication cart in accordance with the Controlled Substances-System Standard policy as of 3/3/25. The Controlled Substance Log will be filled out by a licensed nurse and documentation is completed with each scheduled controlled medication pass. As of 3/3/25, the scheduled controlled medications are also audited at each nursing shift change. Administrator, Director of Nursing and pharmacy consultant worked together to review, revise and create a necessary procedure following current policy to ensure all controlled medications are appropriately secured, stored and reconciled. No change in the disposal of medications is warranted as the continued...	3/13/25

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 15 and maintain a process to accurately identify and reconcile as well as appropriately secure and store scheduled controlled medications in two of two medication carts for eight of eight sampled residents (1, 12, 15, 39, 49, 52, 206, and 306). Findings include: 1. Observation and interview on 2/12/25 at 9:32 a.m. in one of one medication storage room with registered nurse (RN) E and RN U revealed: *The medication storage room utilized a keyless lock entry system that required a code to enter. *There were two medication carts stored inside that room. *The carts contained drawers where the residents' individualized punch-style medication cards (bubble packs) and stock medications were stored. -There were two drawers of each medication cart that stored the majority of the residents' scheduled controlled (medications with risk for abuse and addiction) and non-controlled medication punch cards. -The remaining cart drawers stored stock medications, insulins, eye drops, inhalation medications and additional medical supplies. *Each medication cart had one drawer with a lockable box (lock box) inside of it. -The lock boxes contained a supply of the residents' as needed (PRN) non-controlled Tylenol (acetaminophen) and PRN controlled medications bubble packs. *The storage room utilized a key lock entry cupboard. -The cupboard contained a supply of the residents' scheduled and PRN controlled medications and the emergency medication kit. *A reconciliation/tracking record was used to document the PRN controlled medications and	F 761	current process follows current policy and federal regulations. Process for securing controlled medications has been/will be reviewed individually between Director of Nursing and each licensed nurse on staff responsible for medication administrator by 3/13/25. Beginning 3/10/25, Director of Nursing and Consultant Pharmacist will audit the Controlled Substance Logs weekly for 4 weeks to ensure compliance with policy. After 4 weeks of weekly audits; demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit results will be reported quarterly to the Quality Assurance Performance Improvement Committe by Director of Nursing and Pharmacy Consultant for 6 months. Medication error reports will continue to be discussed at quarterly Quality Assurance Performance Improvement meetings and listed on the Quality Assurance Performance Improvement meeting minutes as per current process.	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 16 scheduled controlled Fentanyl (pain medication) patches. *There were no reconciliation/tracking records for the residents' other scheduled controlled medications. *They confirmed they used reconciliation/tracking records for the residents' PRN controlled medications and scheduled controlled Fentanyl patches to document the counted amounts of those medications. -They explained those medications were counted and documented on those tracking records every shift by two nurses. *They confirmed there were no reconciliation/tracking records maintained to document the amounts of the residents' other scheduled controlled medications. 2. Interview on 2/12/25 at 4:12 p.m. with DON B regarding the accountability of residents' medications process revealed: *The PRN controlled medications were tracked/reconciled. -They did not reconcile/track the scheduled controlled medications. -Two nurses, one coming on duty and one going off duty, were to count and reconcile/track those medications each shift. -The nurses were to count the medications in the bubble packs to reconcile the amounts of the scheduled controlled medications. -The nurses were to reconcile and document the scheduled count of those medications with each medication pass. *She was asked how she would know if a medication bubble pack was tampered with or had a medication missing: -She felt the nurses would notice if a medication bubble pack was tampered with or if there was a	F 761		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 17 missing medication. -The nurses were trained to report a medication discrepancy right away to the DON. *She was asked if she reconciled or destroyed the controlled medications with the pharmacist. -She explained she did not reconcile or destroy medications with the pharmacist. -A nurse on duty would reconcile the medications when they were delivered by the pharmacy. -Two nurses on duty destroy the "controlled" medications. 3. Interview on 2/13/25 at 9:40 a.m. with administrator A regarding the accountability and storage of medications revealed: *She was unsure of the process for the accountability and storage of medications and requested the surveyor to speak to DON B. *Administrator A provided DON B's cell phone number as she was out of the facility on 2/13/25. 4. Interview on 2/13/25 at 10:19 a.m. with consultant pharmacist X revealed: *Asked what the process was to ensure the proper storage, security and tracking of all "controlled" medications. *Asked about the process for the scheduled "controlled" punch card (bubble pack) medications stored in the medication carts among other "non-controlled" punch card (bubble pack) medications that had no reconciliation log/tracking record. * Asked about the distributing pharmacy and consultant pharmacist responsibilities and processes related to "controlled" medications. -He explained he was not employed by the dispensing pharmacy but was contracted by the facility. -He completed the monthly resident chart	F 761		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 18 medication reviews, and checked for outdated supplies and medications monthly in the medication storage room, and medication carts. -He did not review the scheduled controlled medications as the facility did not have reconciliation/tracking records for those medications. -He reviewed the PRN controlled and Fentanyl patch medication reconciliation/tracking records. -The scheduled controlled medications in the medication carts were to be monitored by the nurses. -The nurses were to monitor the medication bubble packs for signs of tampering and potential drug diversion as they administered medications during their scheduled shifts. -He stated schedule II through IV controlled medications should be locked, but some could be stored with non-controlled medications if there is a good system for tracking. -Nurses were to report medication discrepancies to the nursing supervisor. -He agreed that the medication carts are to be within their view at all times if controlled medications are secured with one lock. -He agreed that some controlled medications needed to be secured with two locks and reconciled/tracked at the change of each shift. 5. Interview on 2/13/25 at 12:04 p.m. with administrator A and DON B, who joined by phone at 12:06 p.m., revealed: *A report of residents who had ordered controlled medications was requested, but they were unable to run that report in the EMR system. *The medication error reports for the past six months were requested. -No medication error reports were provided. -Administrator A stated no medication errors had	F 761		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 19 been reported in the past six months. 6. Observation and Interview on 2/13/25 at 12:10 p.m. in the medication storage room with RN E, LPN T, and consultant pharmacist X revealed: *Consultant pharmacist X stated the residents' medications were filled and delivered by the distributing pharmacy according to the printed medication administration records (MARs) provided to the pharmacy by the facility. -Medication bubble packs were filled with either a two-week supply or thirty-day supply of medications. -RN E and LPN T explained that the night nurse would check the medications in and if discrepancies were noted, the pharmacy would be contacted. -The EMR system did not automatically reconcile the scheduled controlled medications. -RN E explained that the nurses reconciled by the printed number on the card. -She further explained if it was the 11th day of the month, the nurse would punch the medication bubble marked with the number 11 to release that medication from the bubble pack medication card. -RN E stated that this was how the nurses would reconcile/track the scheduled controlled medications in the carts. -LPN T confirmed that process. *RN E and LPN T explained that the process was not always followed with new employed nurses. -Some bubble pack cards would be punched starting at the bottom of the card with the number 30. -Some bubble pack cards would be punched starting at the top of the card with the number 1. *Both nurses were unaware of a report that would indicate which residents had ordered controlled	F 761		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 20 medications in the EMR system. *RN E and LPN T went through every resident medication bubble pack in each cart to identify residents who received scheduled controlled medications. -RN E and LPN T confirmed that this was the process they used to identify residents with ordered scheduled controlled medications that did not have reconciliation/tracking records. -After those residents' medication bubble packs were located, LPN T stated, "I think that is all." -Eight residents with controlled medication bubble packs were identified as: *Resident 1 was on a schedule IV medication Lorazepam (a sedative medication) 0.5mg tablet by mouth twice daily (BID). *Resident 12 was on a schedule IV medication Xanax (antianxiety medication) 0.25mg tablet by mouth every night at bedtime (QHS). *Resident 15 was on a schedule IV medication Xanax 0.5mg tablet by mouth twice daily (BID). *Resident 39 was on a schedule IV medication Xanax 0.25mg tablet by mouth every night at bedtime (QHS). *Resident 49 was on a schedule IV medication Tramadol 50mg tablet by mouth twice daily (BID) *Resident 52 was on a schedule II medication Hydrocodone/APAP 5/325mg tablet by mouth every night at bedtime (QHS). *Resident 206 was on a schedule IV medication Xanax 0.5mg tablet by mouth twice daily (BID). *Resident 306 was on a schedule IV medication Tramadol 50mg tablet by mouth twice daily (BID). 7. Review of the provider's 4/8/2024 "Controlled Substances-System Standard Policy" revealed: *"I. Policy:" -"A. It is the policy of Avera to properly acquire, receive, store, administer, track, reconcile,	F 761		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 21 document, and dispose of controlled substances consistent with state and federal guidelines." *"II. Purposes:" -"B. To accurately account for and reconcile controlled substances for prompt identification of loss or potential diversion." -"D. To provide a system that oversees that controlled substances are acquired, handled, administered, reconciled, stored, and disposed of properly." -"E. To assure proper record-keeping for controlled substances." *"III. Procedure:" -"B. Record keeping:" -"1. Log all controlled substances on Resident's Controlled Substance Record form." -"C. Place controlled substance(s) received from the pharmacy in a locked storage area with limited staff access. CII meds will be maintained in a separately locked permanent affixed compartment. Schedule III, IV, V may be stored in a separate locked container or may be integrated with other medications as long as there is a system for accountable tracking (punch cards)." -"E. One authorized person going off duty and one authorized person coming on duty must count and reconcile the accuracy of controlled substance supply for each resident and the facility at the shift change." -"F. Controlled substance records are reconciled by a physical count of the remaining controlled substance supply at the change of each shift by the incoming and outgoing licensed nurse/designee. Controlled substance keys will be reconciled at the same time. " -"NOTE: The controlled substance supply of medication is always secured with two locks. (With the exception of medications that are part of a "single unit package" system when the	F 761		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 761	Continued From page 22 supply is minimal and there is ability to detect a shortage promptly). The locks on the medication cart and the narcotic drawer are always secured."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. 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, interview, record review, and policy review the provider failed to ensure: *Items were not stored under the food preparation sink in one of one kitchen. *Documentation was completed for the cleaning and sanitation of one of one dishwasher. *A process was in place to test and document sanitation levels in sanitation buckets for one of one kitchen. *Refrigerator and freezer temperatures were documented for two of two refrigerators and two	F 812		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 23 of two freezers in one of one kitchen. *Food temperatures were measured prior to serving by one of one cook (G) and documented. *Proper food handling processes were in place for four of four observed certified nursing assistants (CNA M, N, O, and Q) and two of two dietary staff (K, and L) during two of two observed meal services. *Refrigerators had daily temperature documentation completed for seven of seven resident refrigerators(37, 31, 45, 7, 14, 45, and 51) and one of one activity department refrigerator expired food was removed. Findings include: 1. Observation on 2/10/25 at 3:53 p.m. of the kitchen revealed: *Under the sink labeled "Food Preparation sink" were two cabinets. *One cabinet contained the following items: -A green bucket with an unknown black liquid in it. -A silver round pie plate with rust present on the surface. -A flat square metal instrument with a blue handle. -A box of griddle polishing pads stored in corrugated cardboard. -Three plastic fly swatters. -A corrugated cardboard box with ten cc (cubic centimeter) syringes. -A silver squeegee with a black handle. *The second cabinet contained the following items: -Potato press to make fries. -Four small frying pans. -A donut dispenser. -Two large saucepans. -Three small saucepans. -Two pan lids.	F 812	All items under the food preparation sink in the kitchen were removed on 3/4/25. New documentation logs for the dishwasher were made to include a column for the sanitization level of the dishwasher - appropriate sanitization levels of 100 ppm to 150 ppm is listed on the sheet for staff reference. The sanitization level and temperatures will be checked every morning and evening. New documentation logs were made for recording the required food temperatures prior to each meal service for hot foods and cold foods and columns were added for the morning meal items. The Dietary will start using a new Quat sanitizer Oasis 146 Multi Quat Sanitizer for sink and surface sanitation made by Ecolab on 3/14/25 that will keep its effective concentration for up to 7 days. A new spray bottle of the Quat sanitizer will be mixed 1 time per week or as needed if sooner. The Quat sanitizer will be tested for appropriate concentration levels at time of mixing and level will be recorded and the Quat sanitizer will also be tested 2 times per day for correct sanitization levels continued...	3/14/25

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 24 -A grill cleaning brick. -A square metal dish. -A metal cylinder with multiple holes on the sides and a rod in the center. -A squeegee handle. *On the counter there was a white three-ring binder with tabs labeled for each month. *Under the monthly tabs were: -The dishwasher chemical log. -The dishwasher cleaning log. -The freezer and refrigerator temperature log. -The daily temperature for food log. -The walk-in refrigerator and freezer temperature log. Interview on 2/10/25 at 4:18 p.m. with food service manager C revealed the items stored under the sink were items used in the kitchen where residents' food was prepared. 2. Observation on 2/10/25 at 3:48 p.m. of the dishwasher revealed it was a chemical dishwasher. Review of the provider's January 2025 dishwasher chemical log revealed: *The dishwasher chemical log had a column to document the PPM (parts per million) sanitizer concentration. *This log did not include a column to document dishwasher temperature. *There were 13 days without documented chemical concentrations. *There was no chemical concentration documentation from January 8th through January 14th. Review of the provider's January 2025 dishwasher cleaning log revealed:	F 812	and concentration will be recorded. A new Quat sanitizer log has been created to record sanitizer concentration levels - appropriate sanitation levels of 200 ppm - 400 ppm is listed on the log for staff reference. Administrator, Dietician and Dietary Manager reviewed the LTC AEHCC Food Safety and Sanitation policy and revised the policy by adding the changes for the process of the new Quat sanitizer and that no items can be stored under a food preparation sinks. The LTC AEHCC Food Safety and Sanitation policy will be reviewed and education provided to all Dietary staff at meeting on 3/13/25 to include the following topics: maintaining documentation on cleaning and sanitizing the dishwasher, the process to test and document sanitation levels in spray bottle of Quat cleaner, maintaining documentation of refrigerator and freezer temperatures, required food temperatures are measured and recorded prior to each meal services, items may not be stored under food preparation sinks and disposal of expired food items. Audits will be completed by the Dietary Manager weekly for 4 weeks continued...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 25 *There were 12 days of missing documentation in January. *There was no cleaning documented for January 9th through January 14th. 3. Observation on 2/10/25 at 4:00 p.m. of the three-compartment sink in the kitchen revealed: *There are multiple buckets with liquid and a cloth in them. *There was no documentation of the liquid's chemical concentration. Interview on 2/10/25 at 4:04 p.m. with cook I revealed: *Those buckets were sanitation buckets used to wipe surfaces. *The chemical concentration was tested when the liquid was changed, but there was no documentation log. *He indicated the sanitation buckets were changed every hour. Observation and interview on 2/11/25 at 11:04 a.m. of cook H revealed: *He mixed a new bucket of sanitizer. *He did not test the chemical concentration of the contents in the new bucket. *He had filled a new bucket of sanitizing solution. *He did not test the chemical concentration of that solution. *There was no place to document the testing of the chemical concentration of the solution in the buckets. *He tested the buckets once daily. Observation and interview on 2/12/25 at 3:30 p.m. with cook K revealed: *He prepared a sanitation bucket. *He did not test the solution's chemical	F 812	to ensure compliance with no items are kept under the food preparation sink, documentation recorded for sanitization and temperature of the dishwasher, documentation recorded of the required food temperatures prior to each meal service, the documentation reorded of the sanitization level of the Quat sanitizer and the documentation of the recorded temperatures of the refrigerator and freezer. After 4 weeks of weekly audits demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit results will be reported to the Quality Assurance Performance Improvement Committee by the Dietary manager for 6 months. Education provided to all staff at meeting on 3/13/25 regarding policy LTC AEHCC Food and Safety sanitation and glove use/ hand hygiene when handling foods by Dietary manager and Director of Nursing. Education includes information about appropriate glove use when handling ready to eat foods, prohibited bare hand contact and hand hygiene. Weekly audits will be completed by the Director of Nursing, dietary manager or continued...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 26 concentration. *When asked how he would know if the solution had the adequate chemical concentration, he tested the liquid. *The chemical concentration was read to be greater than 200 ppm. *When asked what ppm he expected the solution to be he indicated that he did not know. *He stated that he did not know where to locate that information. *Food service manager C directed him to a three-ring binder to find the information. *The information was observed above the three-compartment sink on a poster labeled "Quaternary Sanitizer", which indicated the concentration should have been between 200-400 ppm. *Also on this poster was a statement that directed staff to "Record the solution concentration reading in the appropriate log." 4. Interview on 2/10/25 at 4:14 p.m. with cook I revealed there were lines through the documentation areas on the temperature logs that indicated the temperatures had not been documented and those lines prevented someone from documenting a temperature on a later date. *Observation and interview on 2/11/25 at 11:10 a.m. with cook G during lunch service revealed: *The display on the Convotherm oven indicated the temperature was set at 212 degrees Fahrenheit. *She removed ground meat and mashed potatoes from the Convotherm oven. *She take had not taken the temperature of the meat or mashed potatoes removed from the Convotherm oven prior to serving. *She stated that the food had been in the	F 812	designated licensed nurse for 4 weeks beginning 3/10/25 to ensure compliance with appropriate glove use, food handling and hand hygiene. After 4 weeks of weekly audits demonstrating expectations being met, montoring will reduce to twice monthly for 3 months; audit results will be reported quarterly for 6 months to the Quality Assurance Performance Improvement Committee by Director of Nursing, Administrator or designated Quality Asssurance nurse until the facility demonstrates sustained compliance determined by the committee. Education provided at meeting on 3/13/25 to Activity and Nursing staff that the Activity room refrigerator temperature needs to be read and logged daily. Education provided on 3/13/25 to all staff that items in a refrigerator need to be discarded after 3 days of the opened date. Weekly audits will be completed by the Activity Manager for 4 weeks beginning on 3/10/25 to ensure temperature readings are being logged daily and outdated foods are being removed from the refrigerator within 3 days after date of opening. After 4 weeks of continued...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 27 Convotherm oven all morning and would be an adequate temperature. Review of the provider's walk-in refrigerator and freezer temperature logs for January 2025 revealed: *The temperature log contained an area for temperature documentation for the refrigerator and the freezer in the "AM" and the "PM". *There was a line drawn through the area to document the "AM" temperatures on 1/8/25, 1/10/25, 1/15/25, 1/20/25, 1/27/25. *There was a line drawn through the area to document the "PM" temperatures on 1/2/25, 1/3/25, 1/7/25, and 1/8/25. Review of the provider's walk-in refrigerator and freezer temperature logs for February 2025 revealed there was a line drawn through the "AM" and "PM" documentation areas on 1/9/25. Review of the provider's January 2025 Refrigerator and Freezer temperature documentation log revealed: *There was a column to document the refrigerator temperature and another to document the freezer temperature. *There was no documentation of the freezer or the refrigerator temperatures for the first seven days in January. *In addition, there was no temperature documentation for the refrigerator or freezer on 1/9/25, 1/18/25, 1/19/25, 1/24/25, and 1/31/25. Review of the provider's January 2025 food daily temperature record revealed: *There was an area to document soup, meat, alternate meat, potatoes, vegetables, alternate vegetables, puree, and other for lunch and	F 812	weekly audits demonstrating expectations are being met; monitoring will reduce to twice monthly for 3 months. Activity Manager will report the findings quarterly to the Quality Assurance Performance Improvement Committee for 6 months. A thermometer was put in Resident 51 refrigerator and Housekeeping manager checked all resident refrigerators to make sure they each had a form on them to record temperatures. Education provided on 3/13/25 to Housekeeping and Nursing staff that the resident refrigerator temperatures need to be read and logged daily. Housekeeping Manager will check refrigerator temperature logs 1 time per week for 3 months to ensure daily readings are being logged. Housekeeping manager will report results to the Quality Assurance Performance Improvement Committee for 6 months.	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 28 supper. *There was no area to document breakfast foods. *There was no area to document the temperatures of refrigerated foods. *There was no temperature documentation for lunch on 1/10/25 and 1/29/25. *There was no temperature documentation for supper on 1/2/25, 1/3/25, and 1/5/25. Interview on 2/12/25 at 3:40 p.m. with food service manager C revealed: *It was his expectation that the sanitation bucket concentration be tested each time a bucket was changed. *The buckets were changed every hour. *He verified there was no log to document the chemical concentration of the sanitation buckets. *He expected food temperatures to be taken and documented every day prior to every meal being served. *He verified there was missing documentation of food temperatures and there was no area for breakfast temperatures to be documented. *It was his expectation that the temperatures for the refrigerators and freezers in the kitchen were checked and documented daily. *Residents' personal refrigerator temperatures were to be monitored by housekeeping. 5. Observation on 2/10/25 at 5:06 p.m. of CNA N serving food revealed: *She had on a pair of gloves. *With those gloved hands she: -Pushed a resident closer to the table. -Turned pages on a 3-ring binder at the serving counter. -Delivered plates of food to residents by placing her thumbs on the edge of the plates. --She did not change her gloves during the meal	F 812		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 29 service. Observation on 2/10/25 at 5:11 p.m. of CNA Q revealed she wore a pair of gloves and cut up two different residents' food items without changing them. Observation on 2/10/25 at 5:13 p.m. of food service work L revealed she had on a pair of gloves, and with those gloved hands she: *Picked up a plastic container of bread that was located in the serving area next to the steam table. *Took bread out of that plastic container and placed it on plates of food to be served to the residents. Observation on 2/10/25 at 5:16 p.m. of CNA M revealed she wore a pair of gloves and with those gloved hands she: *Served two plates of food to residents, with her thumb on the edge of the plate and touching the bread on the plate. *Continued to serve residents plates of food with those same gloved hands. Observation on 2/11/25 at 11:15 a.m. in the dining room of CNA O revealed she: *Used hand sanitizer on her hands and put on a pair of gloves. *Picked up a knife and fork and tried to cut up an unidentified resident's sausage. -The knife was dull, and she was unable to cut the sausage. *Picked up the sausage with those same gloved hands and removed the skin from the sausage. *Placed the skin on a napkin and then picked up that resident 's silverware and cut up his sausage. *Picked up his juice and gave him a drink.	F 812		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 30	F 812		

*Wiped her gloved hands on the napkin that the sausage skin was on.
*Picked up a sausage piece with the resident's fork and then used her gloved hand to slide it off.

Observation on 2/11/25 at 11:35 a.m. of CNA O revealed:
*She took a pair of gloves out of her shirt pocket and put them on.
-She had not completed hand hygiene before putting on the gloves.
*She assisted an unidentified resident with the sausage on his plate.
-She picked up the sausage with her gloved hands, removed the casing from it, and cut it up with a knife.

Observation on 2/11/25 at 11:47 a.m. of food service worker J revealed she passed lunch trays to residents without performing hand hygiene between delivering of each resident's meal tray.

Interview on 2/13/25 at 9:49 a.m. with CNA O regarding her observed glove use in the dining room revealed:
*She used gloves if she was helping a resident with a sandwich or with the sausage if they had to peel the skin off.
*She did not put gloves on if she used a utensil, like a spoon, to help a resident eat.
*She stated she would use hand sanitizer if she changed her gloves.

Interview on 2/13/25 at 10:55 a.m. with administrator A and DON B, who joined by phone, regarding staff glove use in the dining room revealed:
*Glove use was not required in the dining room.
*Staff were expected to use hand sanitizer if they

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 31 were not wearing gloves in any area of the building. *They agreed staff had not used gloves appropriately. 6. Observation on 2/11/25 at 9:12 a.m. of resident 37's refrigerator revealed: *Refrigerator temperature documentation was missing for 2/1/25, 2/2/25, 2/7/25, and 2/10/25. *In the refrigerator was a bag of dates that were not dated and two oranges with brown spots. Observation on 2/12/25 at 9:22 a.m. of resident 31's refrigerator revealed: *A croissant sandwich wrapped in plastic wrap dated 2/1. *Refrigerator temperature documentation was missing for 2/1/25, 2/2/25, 2/8/25, and 2/9/25. Observation on 2/13/25 from 8:35 a.m. to 9:10 a.m. of resident refrigerators revealed: *Resident 45's refrigerator was missing temperature documentation for 2/2/25, 2/3/25, and 2/9/25. *Resident 7's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/8/25, and 2/9/25. *Resident 14's refrigerator was missing temperature documentation for 2/1/25, 2/2/25, 2/8/25, and 2/9/25. *Resident 45's refrigerator was missing temperature documentation for 2/2/25, 2/3/25, and 2/9/25. *Resident 51's refrigerator had a form to document the refrigerator temperatures for January that indicated he had a new refrigerator on 1/24/25. *There was not a form to document February refrigerator temperatures.	F 812		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 32 *There was no thermometer in the refrigerator. Interview on 2/13/25 at 9:40 a.m. with housekeeping manager D regarding resident refrigerators revealed: *Housekeeping staff checked the temperatures of the resident refrigerators Monday through Friday. *No one was responsible for checking resident refrigerator temperatures on the weekends. Observation on 2/13/25 at 12:14 p.m. of the refrigerator in the room identified on the door as the activity room revealed: *There was a piece of paper on the refrigerator door that stated, "This refrigerator is for resident and activity department only." *Refrigerator temperature documentation was missing for 2/1/25, 2/2/25, 2/8/25, and 2/9/25. *Inside the refrigerator was a blue container labeled with a name that was dated 10/2/24. 7. Review of the provider's 5/24 LTC Food Safety and Sanitation policy revealed: *"Gloves will be worn when handling ready to eat foods to ensure that pathogens are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. 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." *"Staff do not need to wear gloves when distributing food or when assisting residents to dine, as long as food is not touched with the bare hand, and or proper handling of utensils, dinnerware is adhered to."	F 812		

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 812	Continued From page 33 *"Sanitizer buckets are changed when visibly soiled or per manufacturer's direction. The sanitizer is checked for proper concentration with test tape (per manufacture's instruction)." *"Cloths must be soaking in sanitizer until use, changing solutions every 4 hours to maintain active concentration. (or per manufacturer's instruction)". *"All refrigerators and freezers have thermometers and temperature is documented at least 1x [one *time] daily." *"Cooked foods must reach the temperature recommended by Food Service Code." *"Hot food is held at a temperature of 140 [degrees] F [Fahrenheit] or above." *"Cold foods are held at a temperature of 40 [degrees] F [Fahrenheit] or less." *Dishwasher "Temperature/appropriate sanitation levels are checked & [and] recorded daily. Review of the provider's 4/23 Food Temperatures policy revealed: *"The food service will follow proper procedures in storing and monitoring food temperatures to prevent the spread of food borne illness." *"Temperatures must be maintained at the following (Fahrenheit) settings for the items indicated below:" -"Frozen food 0 [degrees] or below;" -"Refrigerated food 41 [degrees] or below;" Review of the provider's 4/23 Recording Hot-Cold Food Temperatures policy revealed: *"Record temperatures on food temperature log." *"Continue taking temperatures as needed for each item on menu and recording."	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 34 §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:	F 880	Enhanced Barrier Precautions education was re-assigned on 3/10/25 in the Avera Learning Center for all licensed nurses and Certifed Nurse Assistants to cover enhanced barrier precaution. The lesson includes why Enhanced Barrier precaution is used, how to properly utilize enhanced barrier precaution, and to identify when enhanced barrier precaution should be added to a resident's care. Administrator, Director of Nursing and interdisciplinary team in collaboration with the Medical Director reviewed the policy and procedure related to appropriate hand hygiene and glove use for the assigned task, cleaning and maintenance of multi-use items, storage of items in the beauty shop when not occupied by a practitioner, and use of personal protective equipment by staff when resident is in enhanced barrier precautions. Weekly audits will be completed by the Director of Nursing or designated licensed nurse for 4 weeks beginning 3/10/25 to ensure compliance with enhanced barrier precautions. After 4 weeks of weekly audits demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit results will be reported quarterly for 6 months to the Quality assurance Performance Improvement Committee by Director of Nursing or designated Quality Assurance Nurse until the facility demonstrates sustained compliance determined by the committee.	3/13/25

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 35 (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 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, record review, and policy review, the provider failed to ensure infection prevention practices were performed by: *Not following provider policy for use of personal protective equipment (PPE) for one of one resident (47) on enhanced barrier precautions by one of one staff (LPN F). *Not having placed one of one resident (37) with a pressure ulcer on enhanced barrier precautions. *Not performing appropriate hand hygiene during	F 880	Nebulizer policy review will be completed at Nurse's meeting on 3/13/25 to review Avera LTC - Respiratory Equipment Care policy and appropriate care/cleaning of nebulizer machines; this education will be led by the Director of Nursing. Weekly audits will be completed by the Director of Nursing or designated licensed nurse for 4 weeks beginning 3/10/25 to ensure compliance with nebulizer cleaning policy (Respiratory Equipment Care policy). After 4 weeks of weekly audits demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit results will be reported quarterly for 6 months to the Quality Assurance Performance Improvement committee by the Director of Nursing, Administrator or designated QA nurse until the facility demonstrates sustained compliance determined by committee. Storage bin in tub room has been emptied of multi-use items and those items were disposed of as of 2/14/25. Education will be provided to all nursing staff at meeting on 3/13/25 regarding appropriate use of single-use equipment and appropriate disinfection products/procedures; Director of Nursing will lead the education. Weekly audits will be completed by the Director of Nursing or designated licensed nurse for 4 weeks beginning 3/10/25 to ensure compliance with cleaning Continued...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 36 three of five observations of two of two staff (LPN F and RN S). *Not following provider policy for nebulizer tubing changes for one of two sampled residents (50). *Not cleaning multi-use items properly during three of four observations of one of one of one of one staff (RN S). *Not maintaining the appropriate cleanliness and storage of multi-use items in one of one observed beauty shop and one of one observed tub room. *Inappropriate glove use and hand hygiene during a blood sugar check and with insulin administration by one of one observed staff (RN S). Findings include: 1. Observation on 2/10/25 at 5:00 p.m. of resident 47's room revealed: *A sign on her door indicated enhanced barrier precautions (EBP) (use of gown and gloves during high-contact resident care activities) was required. *A plastic container with drawers containing gowns and gloves was present in her room. Interview on 2/11/25 at 10:18 a.m. with CNA W regarding EBP revealed a gown and gloves were to be when direct care was provided a resident on EBP. Observation and interview on 2/11/25 at 1:57 p.m. of licensed practical nurse (LPN) F while changing resident 47's dressing on her right lower leg revealed: *Resident 47 had an ordered daily dressing change to her right lower leg, where she received a skin graft. *LPN F was seated beside resident 47 as she changed the dressing.	F 880	and maintenance of multi-use items. After 4 weeks of weekly audits demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit results will be reported quarterly for 6 months to the Quality Assurance Performance Improvement Committee by Director of Nursing, Administrator or desingated Quality Assurance nurse until the facility demonstrates sustained compliance determined by the committee. Vanity drawer in beauty shop was cleaned out and all items disposed of and Activity Manager will be ordering a box of disposable combs which can be thrown away after one time use. Three of the 4 rolling hairdryers were removed from the beauty shop and the remaining hairdryer was thoroughly cleaned. A cover has been ordered for the rolling hairdryer to help keep it free of dust. Activity manager will check the drawer in the beauty shop vanity for cleanliness and that the rolling hairdryer is clean and free of dust weekly for 4 weeks beginning on 3/10/25. After 4 weeks of weekly audits demonstrating expectations are met; monitoring will reduce to twice monthly for 3 months. Activity Manager will report findings to the continued....	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 37 *LPN F was not wearing a gown. *LPN F removed her gloves after she completed the dressing change. -She did not perform hand hygiene after she removed those gloves upon completion of the dressing change. Interview on 2/11/25 at 2:03 p.m. with resident 47 revealed she felt staff "at times" wore a gown and gloves when providing her care or changing her dressing. 2. Observation on 2/11/25 at 1:49 p.m. of resident 37's room revealed: *Resident 37 was sitting in her recliner with a Prevalon boot (pressure reduction boots) on her left foot. *She stated that she wore the boot because she had a sore on her heel. *No personal protective equipment (PPE) (gowns, gloves, and eye protection) was observed in or near her room. *There was no sign on her door that indicated EBP was required. Interview on 2/11/25 at 4:05 p.m. with resident 37 revealed staff did not wear a gown when they changed her left heel dressing, helped her with getting dressed, or assisted her with her toileting needs. Review of resident 37's electronic medical record (EMR) revealed: *She was admitted on 3/5/24. *Her 11/18/24 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *Her left heel ulcer was identified on 9/23/24 and was documented to be 4.4 cm (centimeters) by 5	F 880	Quality Assurance Performance Improvement Committee for 6 months. Education folder will be provided to all travel nursing staff upon hire to cover topics including: Enhanced Based Precautions; appropriate hand hygiene/glove use, proper use of single-use patient care items, and appropriate disinfection techniques. This education will be presented by the Director of Nursing or designated licensed nurse upon hire and this education will be in addition to the education that travel staff received in the Avera Learning Center online modules. Audits will be completed weekly beginning 3/10/25 to assess whether new travel staff received and completed the education in the new hire folder; audit results will be reported quarterly to the Quality Assurance PerformanceImprovement Committee by the Director of Nursing for 6 months. Plan of Correction continued on next page...	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 38 cm, brown, dry, and intact. *2/11/25 wound documentation revealed she had a left heel ulcer that was "Open, drainage moderate serosanguineous." *She was being seen by wound care for her left heel ulcer. *There were dressing changes ordered for her left heel ulcer. Review of resident 37's 2/12/25 care plan revealed: *She had an "unstageable left heel Pressure injury/ulcer" that was added to her care plan on 11/19/24. *The care plan did not include the use of EBP. 3. Observation on 2/10/25 at 5:00 p.m. of resident 50's room revealed: *An assembled nebulizer administration set was lying on the nebulizer machine. *There was a date written on the handheld nebulizer device of 1/29. *The date of 1/31 was written on the nebulizer tubing. Interview on 2/11/25 at 8:36 a.m. with resident 50 revealed: *She was admitted to the facility after being hospitalized with a respiratory infection. *She could not recall when she last received a nebulizer treatment. Interview on 2/12/25 at 1:25 p.m. with registered nurse (RN) E regarding resident 50 revealed: *Her last nebulizer treatment was administered on 1/27/25. *Her nebulizer treatments were ordered to be administered as needed. *When nebulizer treatments were administered	F 880	On 3/13/25, a hand hygiene and glove use compentency will be completed by all staff. The competency will be led by an Infection Prevention Nurse and Quality Assurance Registered Nurse. Weekly audits will be completed by the Director of Nursing for 4 weeks of weekly audits demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audit resutsls will be reported quarterly for 6 months to the Quality Assurance Performance Improvement Committee by Director of Nursing, Administrator or designated Quality Assurance nurse until the facility demonstrates sustained compliance determined by the committee.	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 39 as needed it was RN E's practice to dispose of the nebulizer set after a treatment was given and obtain a new set for the next treatment. *RN E reported the documentation in resident 50's EMR, indicated LPN F had documented that she changed resident 50's nebulizer tubing on 2/11/25 at 11:00 a.m. *RN E confirmed that the nebulizer set in resident 50's room was dated 1/29 and 1/31. Review of resident 50's EMR revealed: *She was admitted on 1/7/25. *Her BIMS assessment score of 15, which indicated she was cognitively intact. *She had been hospitalized with pneumonia, bronchitis, and hypoxia (low oxygen in the blood) prior to her admission to the facility. *She had an order for a Xopenex nebulizer as needed for shortness of breath. *There was an order to change the nebulizer tubing weekly and as needed. Review of resident 50's care plan revealed nursing staff were to: *"Provide NEBULIZER meds as ordered" *"Change filter as per facility protocol." *"Change nebulizer tubing weekly." 4. Observation on 2/11/25 at 9:35 a.m. of the facility beauty shop revealed: *One of two drawers of the sink vanity contained four small, white storage containers. *Those four containers stored a variety of beauty shop items. -One contained 11 combs and was visibly soiled with a build up of hair, lint and dust fibers. -One contained two pairs of cutting scissors located on top of the opened soiled scissor case. -The container was visibly dirty with hair, lint and dust fibers.	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 40 -One contained various hair picks, combs, and tweezers and was visibly soiled with hair, lint and dust fibers. *Four of four rolling hairdryers had visibly soiled vent screens that contained a white, dry substance. 5. Observation and Interview on 2/11/25 at 9:41 a.m. with CNA V in one of one north hall tub room revealed: *A storage bin with divided compartments was labeled and stored in the tub room. -It contained the residents' personal nail trimming supplies. *One small compartment bin was unlabeled and stored in the tub room. -It contained one pair of scissors, one large nail clipper, one cuticle clipper, one pair of tweezers, approximately five disposable razors and multiple alcohol pads. -The items in the small bin were multi-use items used for the residents. -CNA V stated the residents' personal clippers and multi-use items were cleaned with alcohol wipes. 6. Observation and Interview on 2/11/25 at 9:58 a.m. with RN S revealed: *RN S performed hand hygiene, removed blood sugar supplies and insulin from the medication cart parked in the dining room. -RN S walked to resident room 51 and entered. -The supplies were placed on the residents visibly soiled walker seat. -RN S applied gloves but did not perform hand hygiene. -RN S did not clean or disinfect the surface area of the walker seat or apply a barrier for the supplies.	F 880	continue	

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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 41 -Resident treatments were completed and the dirty items discarded appropriately. -RN S removed her gloves, she did not perform hand hygiene, and exited the resident room. *Sani wipes with purple lid (germicidal wipes) were used for cleaning the glucometer. She stated, "I wrap the glucometer in [a] wipe for ten minutes." *Staff were provided infection control training upon hire and through staff meetings. 7. Interview on 2/11/25 at 10:18 a.m. with CNA W revealed resident multi-use items and equipment were to be cleaned with Sani-wipes with the purple lid after each use. 8. Observations on 2/11/25 from 1:42 p.m. to 2:02 p.m. with RN S revealed : *Observed RN S exit resident 23 room. - She placed vital signs (VS) equipment (manual blood pressure cuff, an oxygen saturation monitor and a non-contact thermometer) on top of the medication cart. -A stethoscope remained around RN S neck. -RN S removed and discarded her gloves and did not perform hand hygiene. *RN S entered resident 22 room at 1:45 p.m., she performed hand hygiene, applied gloves and administered the residents eye drops. -RN S exited the room at 1:52 p.m. and returned to the medication cart. -She discarded her gloves and performed hand hygiene. *RN S applied gloves, and removed the VS equipment from on top of the medication cart and entered resident 45 1:55 p.m. -RN S placed the VS equipment on resident 45 bedside table. -Resident 45 bedside table was not cleaned or a	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 42 barrier placed before the equipment was placed. -RN S obtained resident 45 vital signs and exited the room at 2:02 p.m. -RN S placed the VS equipment back on top of the medication cart. -RN S removed her gloves, discarded them but did not perform hand hygiene. *The VS equipment was not cleaned or disinfected before or after resident use. *Multi-use equipment and environmental surfaces were not properly cleaned and disinfected to help minimize cross-contamination and the spread of infection. 9. Interview on 2/12/25 at 4:12 p.m. with Infection Preventionist/DON B revealed: *She had completed infection prevention training in the summer of 2024 and obtained a "Long-Term Care Infection Prevention Certification". -Staff were trained on infection control policies and procedures upon hire and yearly. -Staff were monitored through random observations, and audits that were tracked in a binder. -Staff were provided a variety of learning avenues with monthly meetings, annual trainings and competencies. -Infection surveillance was completed and reported to NHSN and QAPI. *Staff should use Sani-wipes (purple top) per the manufacturer's instructions. -She stated, those wipes had "a wet time of two minutes." *She was unaware of the unlabeled compartment bin in the tub room that contained resident multi-use items. -She expected that no multi-use items were to be used and should be removed.	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 43 *She was unaware staff had been using alcohol pads to clean the multi-use items. *Residents should have their own personal items to use. -Cleaning of multi-use items with alcohol pads was not appropriate. *Enhanced barrier precautions (EBP) training/education was provided to staff. *LPN T, or a floor nurse, or she could initiate EBP precautions. -Agreed EBP should be initiated during wound care treatment for residents with pressure sores. -Agreed that EBP was missed and should have been implemented for resident 37. -Agreed the nurse should have worn a gown during wound care treatment for resident 37. *She explained that the beauty personnel brought and stored their beauty products and supplies in the facility beauty shop. -She was unsure of who was responsible for cleaning, maintaining, and ensuring the proper storage of the beauty shop products and supplies and stated "maybe the activities department." -The activities director was out of the facility on 2/12/25 and unable to interview. 10. Review of the provider's 10/24 Transmission Based Precautions and Enhanced Barrier Precautions policy revealed: *"Enhanced Barrier Precautions (EBP): use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing." "Enhanced Barrier Precautions are used during high contact resident care activities for the following residents and should be implemented as facilities are able:" -"Wound requiring a dressing, regardless of MDRO status".	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 44 -If on EBP a "gown and gloves must be used during high contact resident care activities including (but not limited to)" --"wound care (any wound requiring a dressing)". Review of the provider's 12/17/24 Respiratory Equipment Care policy revealed: *"Empty excess fluid, Rinse nebulizer with sterile (preferred) or distilled water, shake off excess moisture, and place on a clean, dry paper towel, and store in a clean, dry location in the resident's room to air dry for the next treatment." *"Replace nebulizer set weekly or more frequently based on MIFU [manufacturer's instructions for use]." Review of the providers 6/13/2024 "Infection Prevention Program and Authority" policy revealed: *"II. Purpose/Responsibilities:" -"A. The function and duties of the Infection Prevention Program shall be to:" -"b. Maintain surveillance of the healthcare facility infection potentials." -"d. Develop and implement a preventative and/or corrective program to minimize infection hazards." -"g. Supervise Infection Control in all phases of healthcare activities and to act upon recommendations made by the Program. This may include:" -"i. Standard precautions and transmission based precautions (Isolation) policies." -"ii. Hand hygiene policy." -"iii. Environmental Cleaning." -"vii. Consultation on and approval of cleaning/disinfection products, procedures, agents, or techniques." -"B. Infection Prevention Practitioner"	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 45 -"h. The Infection Prevention Program must meet standards imposed by OSHA, CMS, and regulatory bodies." Review of the providers 11/2024 "Hand Hygiene" policy revealed: *"I. Purpose." -"I. Hand hygiene (HH) continues to be the primary means of preventing the transmission of infection. -"A. To cleanse hands to prevent the spread of infection." -"B. To provide a clean and healthy environment for residents, staff, and visitors." -"II. Policy." -"A. HH, either with soap and water or with alcohol based hand rub (ABHR)." -"1. immediately before touching a resident." -"2. before a clean procedure or handling an invasive medical device." -"3. after contact with potential for body fluid or contaminated surfaces." -"4. after touching a resident or the resident's immediate environment." -"5. after removing gloves." Review of the providers 10/2024 "Disinfection of Non-Critical Patient Care Equipment" policy revealed: *"A. Purpose." -"B. For the safety and comfort of patients, all reusable ("non-critical") patient care items not sent to Sterile Processing Department (SPD) for reprocessing will be cleaned, disinfected, and maintained in a safe manner between patient use. -"C. Reusable equipment may have specific cleaning and disinfection Instructions for Use (IFU)."	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 46 -"I. Information." -"1. "Non-Critical" items are those that come into contact with intact skin but not mucous membranes. Examples include crutches, blood pressure cuffs, commodes, walkers, wheelchairs, gurneys, pumps, etc. Low level disinfectants (quats) or bleach are used on this kind of equipment." -"II. Policy." -"A. Items taken from a patient's room for use by another patient will be disinfected before use by next patient." -"E. All reusable patient care equipment removed from a patient room/procedure room is disinfected before use on another patient." -"I. Disinfectant Recommendations." -"1. Reusable patient care equipment." -"a. Between each patient use." -"b. Stethoscopes - since stethoscopes typically hang around your neck or in a pocket, disinfect the bell and diaphragm before and after use with an alcohol wipe. Tubing can also be disinfected with an alcohol wipe. This is based upon Littmann Stethoscope Instructions for Use (IFU)." -"III. Procedure." -"A. Don appropriate personal protective equipment (PPE) as needed for the task at hand:" -"1. Gloves - per standard precautions." -"2. Gown - per standard precautions." -"3. Facial protection - per standard precautions." -"C. Using friction, wipe all surfaces with hospital-approved disinfectant. Do not touch cleaned surfaces/items and allow to air dry." -"2. Surfaces should remain wet per required contact time which is stated on the product label:" -"e. PDI Super Sani-Cloth Canister Wipes (purple top) = 2 minutes." -"g. Product varies upon availability and staff are responsible for knowing required wet contact	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 _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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 880	Continued From page 47 times."	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 **01 - MAIN BUILDING 01** B. WING _____	**02/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	**202 J AVENUE** **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
K 000	INITIAL COMMENTS A recertification survey was conducted on 2/12/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Eureka Health Care Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K100 and K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 100 SS=B	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design of one set of ninety-minute fire-rated doors (between the assisted living and the nursing home). Findings include: 1. Observation on 2/12/25 at 2:45 p.m. revealed the cross-corridor ninety-minute fire-rated doors in the two-hour fire separation wall between the assisted living and the nursing home had a one-half inch gap between the doors at the lower half of the doors.	K 100	New metal doors with appropriate fire rating and vision panels measuring 5" x 26" have been ordered from House of Glass on 3/10/25. Plant Operations Manager will report at the next Quality Assurance Performance Improvement meeting that the doors were replaced.	3/14/25

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

Carmen Weber

TITLE
Administrator

(X6) DATE
3/7/25

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 _____	**02/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	**202 J AVENUE** **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
K 100	Continued From page 1 Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency could affect 100% of the occupants of the smoke compartment.	K 100		

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 _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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
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 on 2/12/25. 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 | 3/7/25

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.

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
	10618	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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) COMPLETE DATE
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 2/10/25 through 2/13/25. Avera Eureka Health Care Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/10/25 through 2/13/25. Avera Eureka Health Care Center was found not in compliance with the following requirement: S167.	S 000		
S 167	44:73:02:18(3-4) Occupant Protection The facility shall: (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system must be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain an unobstructed nurse call cord in one location (east side of the tub room). Findings include: 1. Observation on 2/12/25 at 2:20 p.m. revealed the nurse call cord for the east side of the tub	S 167	Stand was removed from east side of tub room on 2/14/25 and education was provided to bath aides on 2/14/25 on importance of keeping call cord area free of obstructions. Will provide facility wide education to all staff on 3/13/25 on call system being easily accessible/activated by resident. Director of Nursing or designated licensed nurse will audit weekly for 6 months beginning 3/10/25 to ensure that call cord in east side of tub room is not obstructed. Audit results will be reported quarterly to the Quality Assurance Performance Improvement Committee by Director of Nursing or designess for 6 months.	2/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Weber
TITLE: Administrator
(X6) DATE: 3/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10618	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE 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) COMPLETE DATE
S 167	Continued From page 1 room was obstructed by a stand holding a plastic cabinet with resident toiletry items. Interview with the maintenance supervisor at that same time confirmed that finding.	S 167		