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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 3/19/24 through 3/21/24. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F697, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/19/24 through 3/21/24. Areas surveyed included quality of care and treatment which included falls and resident choices. Avera Maryhouse Long Term Care was found in compliance.	F 000	The facility does ensure pain management interventions are in place for residents who have pain prior to a dressing change. All residents are potentially at risk. Resident #7's care plan has been reviewed and revised to include pain management interventions to be used prior to a dressing change. Director of Nursing (DON) will educate all nurses to ensure to assess resident pain with the resident prior to completing a dressing change and to add pain management interventions to the care plan that are acceptable for each resident with a dressing change. The in-service will be completed by 4/26/24. DON or designee will complete 2 audits/week X 4 weeks, then 4/month X 3 months to ensure nurses are assessing for pain and implementing a pain management intervention prior to initiating a dressing change if needed. Results of the audits willl be reported by the DON and discussed at the bi-monthly Quality Assurance Performance Improvement (QAPI) meeting for further review and recommendations and /or continuation/discontinuation of audits.	5/3/24
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one licensed practical nurse (LPN) (G) implemented a pain management intervention for one of one sampled resident (7) who complained of left foot pain before a dressing change. Findings include: 1. Observation and interview on 3/19/24 at 9:40 a.m. with resident 7 in his room revealed he: *Was seated in a recliner reviewing customer account information for his business.	F 697		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Talli Raske | Administrator | 4/9/24

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
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 697	Continued From page 1 *Had a history of a fall that resulted in fractured back vertebrae. -Used a pain patch to manage his back pain. *Had left foot pain that was more bothersome to him than his back pain. -A blister on the top of that foot had popped and the bandage covering his foot was changed daily. Observation on 3/19/24 at 10:03 a.m. of licensed practical nurse (LPN) G completing resident 7's left foot dressing change revealed: *She asked the resident before starting the dressing change what number between zero and ten on a pain scale that rated his foot pain. -Zero was no pain and ten was the worst possible pain. *He rated his pain an "8". *Without offering him any pain relief options or interventions LPN G initiated and completed the resident's dressing change. *Pain medication was offered after the dressing change was completed. -LPN G gave medication options including tramadol or Tylenol for pain and the resident requested tramadol because Tylenol "doesn't do anything" for my discomfort. Interview and record review on 3/19/24 at 10:20 a.m. regarding resident 7's March 2024 Medication Administration Record with LPN G after leaving his room following the dressing change revealed: *"I didn't know it [the dressing change] was going to be painful [to the resident]. I should have given him something prior to the treatment." *Tramadol was last administered at 12:53 a.m. on 3/19/24 and was able to have been administered every six hours as needed.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 697	Continued From page 2 Interview on 3/19/24 at 10:22 a.m. with resident 7 in his room while LPN G administered his tramadol revealed he: *Re-iterated his foot pain score was an "8". -Described his foot pain as "jolting" like electricity and felt like nerve pain. Review of resident 7's electronic medical record (EMR) revealed: *His diagnoses included: chronic peripheral venous insufficiency, chronic kidney disease, and chronic lower extremity edema. *Between 3/1/24 and 3/20/24 the resident was administered at least one tramadol dose daily except for five days. *Tylenol was last administered on 3/2/24. *His 1/25/24 care plan interventions related to pain revealed: -His pain was controlled with a Lidocaine patch, scheduled muscle relaxants, and as needed tramadol. -No non-pharmacological interventions for pain management were identified. -The resident "will have an acceptable-to-resident 7-pain level during TCU [transitional care unit] stay." --There was no indication of what the resident considered to have been an acceptable pain level. 2. Interview on 3/20/24 at 8:15 a.m. with resident 7 revealed: *His left foot dressing change was just completed. *His pain post-dressing change was a "7" or "8". -The onset of his pain occurred at the time the dressing was removed off the top of his foot and the bare skin was exposed to the air.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 697	Continued From page 3 Interview on 3/20/24 at 8:20 a.m. and again at 11:30 a.m. with registered nurse I revealed: *Tramadol was administered to the resident at 6:25 a.m. that morning for a reported left foot pain score of a "4". *She completed the resident's left foot dressing change at about 8:00 a.m. that morning. *The resident activated his call light at 8:30 a.m. after the dressing change and complained of back and foot pain. -It was too soon to administer an additional tramadol and non-pharmacological interventions including leg elevation and relaxation were encouraged. Interview on 3/21/24 at 11:30 a.m. with director of nursing B and administrator C revealed: *LPN G was expected to have addressed resident 7's pain complaint before initiating his dressing change. *The resident's pattern of tramadol use should have been reviewed to determine if he would have benefited from some type of scheduled pain relief plan. *Specific non-pharmacological pain management interventions were expected to have been identified on the resident's care plan. *A definition of what the resident considered to have been "acceptable pain" was expected to have been reflected in his care plan. Review of the December 2018 revised Pain Management policy revealed: *"10. Management of pain: In collaboration with the physician/prescriber, the facility staff develops, implements, monitors and revises as necessary interventions to prevent or manage the individual resident's pain, beginning at admission."	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 697	Continued From page 4 *"13. Monitoring, reassessment, and care plan revision. Monitor the resident over time to determine the extent to which pain is being controlled. Revise plan if needed."	F 697		
F 812 SS=E	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, and policy review, the provider failed to: *Maintain the following in one of one service kitchen in a clean and sanitary manner: -Two of three silverware holders on one of one dish drying rack. -One of one plastic wrap dispenser. -One of one beverage dispenser station. -One of one stack of uncovered kitchen towels. -One of one plastic bag of "to go" food containers.	F 812	The facility does ensure to maintain the kitchen in a clean and sanitary manner. This includes cleanliness of the silverware holder, dish drying rack, plastic wrap dispenser, and beverage dispenser station. Also to ensure towels are stored appropriately and to ensure the plastic bag of the disposable "to go" food containers is closed. All residents are potentially at risk. The Food and Nutrition Services (FNS) Manager will educate all FNS Maryhouse staff to ensure the kitchen is maintained in a clean and sanitary manner. Training will include: ensuring the silverware holders, dish drying rack, plastic wrap dispenser, and beverage dispenser station are clean and to ensure kitchen towels are not stored by a garbage can and to ensure the plastic bag of the "to go" food containers is closed. The in-service will be completed by 4/26/24. FNS Manager or designee will complete 2 audits/week for 4 weeks, then 1 audit/week X 3 months to ensure the Maryhouse kitchen is	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 5 Findings include: 1. Observation and interview with nutrition and food service employee E on 3/19/24 at 11:15 a.m. during the initial kitchen tour revealed: *Attached to the dish drying rack next to the three-compartment sink were three plastic silverware holders. -Inside one of the two white plastic holders were several utensils pointed downward inside of the holder and touching the bottom of it. --The bottom of that holder was rust-colored in appearance. -The second plastic holder was empty and the bottom of that holder was rust and black-colored in appearance. *On the counter next to the steam table was a plastic wrap dispenser. -The top of the dispenser had clear-colored build-up on it and the device that slid across the plastic wrap to cut it had several brown stains on it. 2. Observation on 3/19/24 at 11:25 a.m. of the dining room beverage station revealed: *The stainless-steel station was located next to the kitchen serving window. *Between the coffee and juice machines was a folded white towel. -The side of the towel closest to the coffee machine was stained brown. *Beneath the coffee machine was an open storage area. -On the bottom shelf there were two separate rows of coffee cups. --Between those two rows near the front of that shelf were several coffee-stained areas. -On the top shelf there were two separate rows of coffee cups and coffee carafes.	F 812	maintained in a clean and sanitary manner. Results of the audits will be reported by the FNS Manager or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 6 --Between those two rows near the front of that shelf were several coffee-stained areas. 3. Continued observation and interview on 3/19/24 between 11:30 a.m. and 11:40 a.m. with nutrition and food service employee E in the service kitchen revealed: *Inside the hallway door entrance was a tall, opened cardboard box. -An opened plastic bag inside of that box held disposable "to-go" food storage containers stacked as high as the opening of the box. --The containers were used by residents to transport food items. *Behind the door that opened into the kitchen from the dining room was a garbage can with a lid able to be flipped. -Directly behind that garbage can were uncovered, stacked kitchen towels on a cart. --Those towels were used to wipe off wet meal trays or to cover food items during transport. 4. Observation and interview on 3/20/24 at 8:00 a.m. with nutrition and food service employee E regarding kitchen and dining area cleaning revealed: *The areas in the service kitchen and at the beverage station referred to above remained unchanged from the observations made on 3/19/24. *There was a cleaning checklist completed daily by food service staff who worked the evening shift. -Those staff consisted of mostly high school students. *There was no cleaning checklist form food service staff to complete during the day. -Those staff were long-time employees and knew what was expected to have been completed.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 7 5. Interview on 3/20/24 at 11:50 a.m. with nutrition and food services manager F regarding the kitchen and beverage station observations referred to above revealed: *The areas described above in the kitchen and dining areas were not maintained in a sanitary manner. *There was currently no process for auditing the completed evening cleaning checklists to ensure compliancy. -The cleaning checklist might need re-evaluation and a day time cleaning checklist might need to be initiated. 6. Review of the revised March 2024 LTC (Long Term Care) Food Safety and Sanitation-System Standard policy revealed: "Maintaining high standards of sanitation and prevention infection in Nutrition Services Department require health personnel, properly maintained equipment, uncontaminated supplies and an ongoing awareness, practice, and monitoring of proper sanitation and hygiene. "	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880	The facility does ensure infection prevention and control practices are implented for proper disinfection of the rubber seal on an insulin vial and proper glove use while completing a resident's dressing change. All residents are potentially at risk. No corrections could be done for resident 31 or 7	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 8 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880	The Director of Nursing will educate all nurses to ensure infection prevention and control practices are being followed for proper disinfection of the rubber seal on a resident's insulin vial before inserting the syringe needle and proper glove use during a resident's dressing change. DON or designee will complete 2 audits/week X 4 weeks, then 4 audits/month X 3 months to ensure infection prevention and control practices are being followed. Results of the audits will be reported by the DON and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 9 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 and control practices were implemented for the following: *Disinfection of the rubber seal on one of one sampled resident's (31) insulin vial by one of one licensed practical nurse (LPN) (H) before inserting the syringe needle. *Proper glove use during one one of one sampled resident's (7) dressing change by one of one LPN G. Findings include: 1. Observation and interview on 3/19/24 at 8:20 a.m. with LPN H preparing resident 31's insulin administration revealed she: *Did not wipe the rubber seal on his Levemir insulin vial with an alcohol pad before piercing it with a syringe. -Was expected to have wiped the seal with an alcohol pad prior to piercing it. 2. Review of resident 7's electronic medical	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 10 record revealed: *His diagnoses included chronic peripheral venous insufficiency, chronic kidney disease, and chronic lower extremity edema. *He developed an eight-centimeter by nine-centimeter blister on the top of his left foot that opened up on 2/28/24. -Dressing changes to that foot occurred twice daily and as needed. *Wound assessments described the top of his foot as pink and moist with scant to moderate clear drainage and no signs of wound infection. Observation on 3/19/24 at 10:03 a.m. of LPN G performing resident 7's left foot dressing change revealed: *The resident was seated in a recliner in his room. *LPN G performed hand hygiene, put on a gown, and a clean pair of gloves then: -Lifted a red metal box sitting on top of the chair in front of the resident's recliner and moved it. -Moved the chair the box sat on out of the way. -Lifted the resident's walker by its handles from in front of him and moved it. -Removed the resident's left sock. *Without changing her gloves, performing hand hygiene, and putting on a clean pair of gloves she removed the pad from the top of his foot. *After discarding the pad she removed her gloves, performed hand hygiene, put on a clean pair of gloves and completed the dressing change. Interview on 3/19/24 at 10:30 a.m. with LPN G after resident 7's dressing change was completed revealed she should have removed her gloves, performed hand hygiene, and put on a pair of clean gloves after handling high-touch items like	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 11 the red box, the chair, the walker, and the sock before touching the Vaseline gauze pad on the resident's foot. Interview on 3/21/24 at 11:00 a.m. with director of nursing B and administrator C regarding the observations referred to above revealed: *Insulin preparation practices including disinfection of the rubber seal of the insulin vial were not followed according to the policy regarding safe injection practices. *Glove removal, hand hygiene, putting on a pair of clean gloves after handling high-touch surfaces and before removing resident 7's dressing was expected to mitigate the risk of exposing contaminants to the resident's opened skin on his foot. Review of the revised December 2023 Safe Injection Practices-Medication Injections policy revealed: *"IV Frequently Asked Questions Regarding Safe Practices for Medical Injections:" -A. 1. "b. Proper hand hygiene should be performed before handling medications and the rubber septum should be disinfected with alcohol prior to piercing it." Review of the November 2023 revised Avera LTC (Long Term Care) Standard Precautions policy revealed: "Gloves may need to be changed during the care of an individual patient [resident]." -Gloves should be changed after contact with a contaminated site and before contact with a clean site on the same resident.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(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 from 3/19/24 through 3/21/24. Avera Maryhouse Long Term Care was found in compliance.	E 000		4/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Talli Raske	Administrator	4/9/24

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 EAST DAKOTA PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/19/24. Avera Maryhouse Long Term Care (Building 1) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/20/24. Please mark an F in the completion date column for K226 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=C	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, testing, interview, and	K 226		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske
TITLE: Administrator
(X6) DATE: 4/9/24

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
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 226	Continued From page 1 document review, the provider failed to maintain ninety-minute horizontal exit doors in operating condition. The horizontal doors separating building 1 and building 2 on the second floor when closed provide a gap clearance between the door and the floor greater than 3/4-inch. Findings include: 1. Observation and testing on 3/19/24 at 1:45 p.m. revealed the cross-corridor horizontal exit doors separating building 1 and building 2 on the second floor when closed failed to maintain the ninety-minute, fire-resistive rating of the assembly. The doors when closed provide a gap greater than 3/4-inch between the carpeted floor and the bottom of the door. NFPA 80 Article 3-6 indicates clearances should be no greater than 3/4-inch from the floor to the bottom of the door. Interview with the supervisor of facility services at the time of the above observation and testing confirmed that finding. He indicated the door had been adjusted but could not be lowered any further. Lowering the door further would cause it to catch on the floor when in the open position. If the door were to catch on the floor it could prevent the automatic self-closing mechanism from functioning. Review of the previous life safety code survey dated 3/16/23 confirmed the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA PIERRE, SD 57501**

(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 918	Continued From page 2	K 918		
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918	The facility does ensure to document generator battery conductivity value monthly. All residents are potentially at risk. The Administrator and or Facilities Director will educate the Plant Ops Technician to ensure to document the generator battery conductivity value every month. The in-service will be completed by 4/19/24. The Administrator or designee will complete monthly audits X 4 months to ensure the above documentation is logged appropriately. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly Quality Assurance Performance Improvement meeting for further review and recommendations and/or continuation/discontinaution of audits.	5/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 918	Continued From page 3 Based on record review and interview, the provider failed to document generator battery conductivity value monthly (no documentation for July, August, and September 2023). Findings include: 1. Record review on 3/19/24 at 1:45 p.m. revealed there was no documentation of the battery conductivity in the monthly maintenance logs for the generator for the months of July, August, and September for the calendar year 2023. Interview with the plant operations supervisor at 2:00 p.m. on 3/19/24 revealed the monthly battery conductivity documentation requirement was marked as checked during the above-mentioned months. He further stated other months had the conductivity value noted on the maintenance record form. The deficiency affected 100% of the building occupants.	K 918		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA PIERRE, SD 57501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/19/24. Avera Maryhouse Long Term Care (Building 2) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/20/24. Please mark an F in the completion date column for K226 and K311 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=C	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, testing, interview, and	K 226		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske
TITLE: Administrator
(X6) DATE: 4/9/24

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
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 226	Continued From page 1 document review, the provider failed to maintain ninety-minute horizontal exit doors in operating condition. The horizontal doors separating building 1 and building 2 on the second floor when closed provide a gap clearance between the door and the floor greater than 3/4-inch. Findings include: 1. Observation and testing on 3/19/24 at 10:30 a.m. revealed the cross-corridor horizontal exit doors separating building 2 and building 1 on the second floor when closed failed to maintain the ninety-minute, fire-resistive rating of the assembly. The doors when closed provide a gap greater than 3/4-inch between the carpeted floor and the bottom of the door. NFPA 80 Article 3-6 indicates clearances should be no greater than 3/4-inch from the floor to the bottom of the door. Interview with the supervisor of facility services at the time of the above observation and testing confirmed that finding. He indicated the door had been adjusted but could not be lowered any further. Lowering the door further would cause it to catch on the floor when in the open position. If the door were to catch on the floor it could prevent the automatic self-closing mechanism from functioning. Review of the previous life safety code survey dated 3/16/23 confirmed the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA PIERRE, SD 57501**

(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 311	Continued From page 2	K 311		F
K 311 SS=C	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and review of previous survey document records, the provider failed to maintain a protected path of egress. The east stair enclosure discharged past unprotected window openings. Findings include: 1. Observation on 3/19/24 at 1:15 p.m. revealed the exterior sidewalk and steps from the east exit stair enclosure discharged past unprotected window openings. Review of the previous life safety code survey confirmed that the condition had existed since the original construction. The deficiency affected one of numerous requirements for maintaining protected paths of egress. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 311	Continued From page 3 standards.	K 311		
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918	The facility does ensure to document generator battery conductivity value monthly. All residents are potentially at risk. The administrator and or Facilities Director will educate the Plant Ops Technician to ensure to document the generator battery conductivity value every month. The in-service will be completed by 4/19/24. The Administor or designee will complete monthly audits X 4 months to ensure the above documentation is logged appropriately. Results of the audits will be reported by the Administrator or designee and discussed at teh bi-monthly QAPI meeting for further review and recommendations and/or continuation/ discontinuation of audits.	5/3/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA PIERRE, SD 57501**

(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 918	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator battery conductivity value monthly (no documentation for July, August, and September 2023). Findings include: 1. Record review on 3/19/24 at 1:45 p.m. revealed there was no documentation of the battery conductivity in the monthly maintenance logs for the generator for the months of July, August, and September for the calendar year 2023. Interview with the plant operations supervisor at 2:00 p.m. on 3/19/24 revealed the monthly battery conductivity documentation requirement was marked as checked during the above-mentioned months. He further stated other months had the conductivity value noted on the maintenance record form. The deficiency affected 100% of the building occupants.	K 918		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA PIERRE, SD 57501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/19/24. Avera Maryhouse Long Term Care (Building 3) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/20/24. Please mark an F in the completion date column for K311 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 311 SS=C	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.	K 311		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Talli Raske | Administrator | 4/10/24

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
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 311	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and previous survey document review, the provider failed to maintain the one-hour, fire-resistive rating for three of three stair enclosures (north and east of the activities room and the southeast stairs). Findings include: 1. Observation on 3/19/24 revealed three stair enclosures with doors without a label identifying their fire-resistive rating. Those doors were 1 and 3/4-inch hollow metal doors. The doors were located at the following locations: *To the stair enclosures north of the activities room on the first and second floors. *To the stair enclosures east of the activity room on the first and second floors. *To the southeast stair enclosures on the first and second floors. Review of the previous life safety code survey dated 3/16/23 confirmed that the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety standards.	K 311		
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918	The facility does ensure to document generator battery conductivity value monthly. All residents are potentially at risk.	5/3/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 918	Continued From page 2 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator battery conductivity value monthly (no documentation for July, August, and September 2023). Findings	K 918	The Administrator and or Facilities Director will educate the Maintenance Technician to ensure to document the generator battery conductivity value every month when testing the generator. The in-service will be completed by 4/19/24. The Administrator or designee will complete monthly audits X 4 months to ensure the above documentation is logged and documented appropriately. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations an/or continuation/ discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**717 EAST DAKOTA** **PIERRE, SD 57501**

(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 918	Continued From page 3 include: 1. Record review on 3/19/24 at 1:45 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator for the months of July, August, and September for the calendar year 2023. Interview with the plant operations supervisor at 2:00 p.m. on 3/19/24 revealed the monthly battery conductivity documentation requirement was marked as checked during the above-mentioned months. He further stated other months had the conductivity value noted on the maintenance record form. The deficiency affected 100% of the building occupants.	K 918		

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
	10662	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	717 E DAKOTA PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/19/24 through 3/21/24. Avera Maryhouse Long Term Care was found in compliance.	S 000		4/9/24
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 3/19/24 through 3/21/24. Avera Maryhouse Long Term Care was found in compliance.	S 000		4/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske

TITLE: Administrator

(X6) DATE: 4/9/24

STATE FORM 6899 ENZ911 If continuation sheet 1 of 1