PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	CX3) DATE SURVEY COMPLETED C
		435034	B. WING		03/21/2024
	ROVIDER OR SUPPLIER ARYHOUSE LONG TERN	I CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	50 114 1 11 1 1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	with 42 CFR Part 483 for Long Term Care fa 3/19/24 through 3/21/ Term Care was found	h survey for compliance s, Subpart B, requirements acilities was conducted from 24. Avera Maryhouse Long not in compliance with the s: F697, F812, and F880.	F 000	The facility does ensure pain management interventions are place for residents who have prior to a dressing change. All residents are potentially at ris Resident #7's care plan has be reviewed and revised to include	pain I k. een de
	CFR Part 483, Subpater Term Care facilities withrough 3/21/24. Area of care and treatment resident choices. Avecare was found in contain Management CFR(s): 483.25(k) §483.25(k) Pain Management facility must ensure provided to residents consistent with professional sides.	agement. Ire that pain management is who require such services, ssional standards of practice,	F 69	management interventions to care plan that are acceptable each resident with a dressing change. The in-service will be completed by 4/26/24.	eain the for
	and the residents' gor This REQUIREMENT by: Based on observatio and policy review, the one of one licensed p implemented a pain n one of one sampled r of left foot pain before Findings include: 1. Observation and in a.m. with resident 7 in *Was seated in a recl account information for	n, interview, record review, e provider failed to ensure tractical nurse (LPN) (G) management intervention for esident (7) who complained a dressing change. Interview on 3/19/24 at 9:40 in his room revealed he: iner reviewing customer or his business.		DON or designee will complete audits/week X 4 weeks, then 4/month X 3 months to ensure nurses are assessing for pain implementing a pain manager intervention prior to initiating a dressing change if needed. Results of the audits will be not by the DON and discussed at bi-monthly Quality Assurance Performance Improvement (Comeeting for further review and recommendations and /or continuation/discontinuation of	e and ment a eported the
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE 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 ballients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a pain 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. program participation.

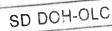
FORM CMS-2567(02-99) Previous Versions Obsolete

Talli Raske

Event ID: XGEK11

Facility ID: 0019

If continuation sheet Page 1 of 12



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	NG		MPLETED
		435034	B. WNG_		,	C 03/21/2024
	ROVIDER OR SUPPLIER	I CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 697	back vertebrae. -Used a pain patch to *Had left foot pain that him than his back pain -A blister on the top of the bandage covering. Observation on 3/19/ practical nurse (LPN) left foot dressing chat *She asked the resid dressing change what ten on a pain scale the -Zero was no pain an *Without offering him interventions LPN G resident's dressing of *Pain medication was change was complete -LPN G gave medicate tramadol or Tylenol for requested tramadol be anything" for my disconstitution Interview and record a.m. regarding resided Medication Administrater leaving his room change revealed: *"I didn't know it [the to be painful [to the re him something prior *Tramadol was last as *"I remadol was last as *"I rema	Il that resulted in fractured o manage his back pain. at was more bothersome to in. If that foot had popped and g his foot was changed daily. 24 at 10:03 a.m. of licensed o G completing resident 7's inge revealed: ent before starting the at number between zero and hat rated his foot pain. Ind ten was the worst possible "8". any pain relief options or initiated and completed the hange. Is offered after the dressing ed. Ition options including or pain and the resident because Tylenol "doesn't do comfort. review on 3/19/24 at 10:20 ent 7's March 2024 ration Record with LPN G in following the dressing dressing change] was going esident]. I should have given to the treatment." Idministered at 12:53 a.m. on es to have been administered	F	597		

		(X3) DATE SURVEY COMPLETED			
		435034	B. WING		03/21/2024
	ROVIDER OR SUPPLIER ARYHOUSE LONG TERM			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	7 7 —
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F 697	in his room while LPN tramadol revealed he *Re-iterated his foot particle and felt like nerve paid Review of resident 7's (EMR) revealed: *His diagnoses includivenous insufficiency, chronic lower extremi *Between 3/1/24 and administered at least except for five days. *Tylenol was last adm *His 1/25/24 care plangain revealed: -His pain was controll scheduled muscle relitramadolNo non-pharmacologmanagement were idented and the resident "will have 7-pain level during Tostay."There was no indicated considered to have be level. 2. Interview on 3/20/27 revealed: *His left foot dressing completed. *His pain post-dressing-The onset of his pair	at 10:22 a.m. with resident 7 I G administered his : pain score was an "8". ain as "jolting" like electricity in. Is electronic medical record Ided: chronic peripheral chronic kidney disease, and ity edema. 3/20/24 the resident was one tramadol dose daily ininistered on 3/2/24. In interventions related to interventions related to led with a Lidocaine patch, axants, and as needed gical interventions for pain entified. Ided with a Lidocaine patch, axants, and as needed countified. Ided with a Lidocaine patch, axants, and as needed countified. Ided with a Lidocaine patch, axants, and as needed countified. Ided with a Lidocaine patch, axants, and as needed countified. Ided with a Lidocaine patch, axants, and as needed countified. Ided with a Lidocaine patch, axants, and as needed countified. Ided with a Lidocaine patch, axants, and as needed countified. In case of the countified	F	697	

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F 697	Interview on 3/20/24 a 11:30 a.m. with regist *Tramadol was admir 6:25 a.m. that mornin score of a "4". *She completed the rechange at about 8:00 *The resident activate after the dressing cha back and foot painIt was too soon to ac tramadol and non-pha including leg elevation encouraged. Interview on 3/21/24 a nursing B and admini *LPN G was expected resident 7's pain com dressing change. *The resident's patter have been reviewed a have benefited from a relief plan. *Specific non-pharma interventions were ex identified on the resid *A definition of what th have been "acceptab have been reflected i Review of the Decem Management policy re *"10. Management of the physician/prescrit develops, implements	at 8:20 a.m. and again at ered nurse I revealed: histered to the resident at g for a reported left foot pain esident's left foot dressing a.m. that morning. Ed his call light at 8:30 a.m. ange and complained of Iminister an additional armacological interventions in and relaxation were at 11:30 a.m. with director of strator C revealed: In the director of strator C revealed: In the director of strator before initiating his in of tramadol use should to determine if he would some type of scheduled pain acological pain management spected to have been lent's care plan. The resident considered to le pain was expected to in his care plan. In acological revised Pain evealed: In a collaboration with poer, the facility staff is, monitors and revises as ans to prevent or manage the	Fé	697		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
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	revision. Monitor the determine the extent controlled. Revise pla	sessment, and care plan resident over time to to which pain is being n if needed." ore/Prepare/Serve-Sanitary	F 69	² The facility does ensure to m the kitchen in a clean and sa	nitary
	state or local authoriti (i) This may include for from local producers, and local laws or regulation in the following the follow	re food from sources ed satisfactory by federal, es. ood items obtained directly subject to applicable State alations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and ince with professional rvice safety. is not met as evidenced in, interview, and policy ailed to: g in one of one service if sanitary manner: are holders on one of one rap dispenser.		manner. This includes cleanly of the silverware holder, dish rack, plastic wrap dispenser, beverage dispenser station. It to ensure towels are stored appropriately and to ensure the plastic bag of the disposable food containers is closed. All residents are potentially at rist. The Food and Nutrition Servi (FNS) Manager will educate and Maryhouse staff to ensure the kitchen is maintained in a cleand sanitary manner. Training include: ensuring the silverway holders, dish drying rack, pla wrap dispenser, and beverage dispenser station are clean at to ensure kitchen towels are stored by a garbage can and ensure the plastic bag of the food containers is closed. The in-service will be completed to 4/26/24. FNS Manager or designee we complete 2 audits/week for 4 then 1 audit/week X 3 monther ensure the Maryhouse kitcher.	drying and Also he "to go" sk. ces all FNS e an g will are stic le nd not to go" e by ill weeks, s to

Facility ID: 0019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)		(X3) DATE SURVEY COMPLETED C			
		435034	B. WING	· · · · · · · · · · · · · · · · · · ·	03/21/2024
	ROVIDER OR SUPPLIER ARYHOUSE LONG TERM	M CARE	,	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	
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F. 812	food service employed during the initial kitch *Attached to the dish three-compartment silverware holdersInside one of the two several utensils point holder and touching terms are several utensils point holder and the dispersareThe second plastic hottom of that holder in appearance. *On the counter next plastic wrap dispensesThe top of the dispersil build-up on it and the plastic wrap to cut it lit. 2. Observation on 3/dining room beverage. *The stainless-steel second plastic holders.	atterview with nutrition and the E on 3/19/24 at 11:15 a.m. en tour revealed: drying rack next to the ink were three plastic of white plastic holders were the downward inside of the the bottom of it. holder was rust-colored in holder was empty and the was rust and black-colored to the steam table was a ter. Inser had clear-colored to device that slid across the had several brown stains on 19/24 at 11:25 a.m. of the estation revealed: station was located next to	F 812	maintained in a clean and manner. Results of the audits will be reported by the FNS Mana designee and discussed at bi-monthly QAPI meeting f further review and recommand/or continuation/discon of audits.	e ger or t the or nendations
	folded white towel. -The side of the tower machine was stained. *Beneath the coffee istorage area. -On the bottom shelf rows of coffee cups. Between those two shelf were several control of the several control.	and juice machines was a el closest to the coffee l brown. machine was an open there were two separate rows near the front of that offee-stained areas. re were two separate rows of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		435034	B. WING _		03/21/2024	
	ROVIDER OR SUPPLIER	I CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501		
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F 812	shelf were several co 3. Continued observa 3/19/24 between 11:3 nutrition and food ser service kitchen revea *Inside the hallway do opened cardboard bo -An opened plastic bo disposable "to-go" for stacked as high as th The containers were transport food items. *Behind the door that from the dining room able to be flipped. -Directly behind that uncovered, stacked k Those towels were trays or to cover food 4. Observation and ir a.m. with nutrition an regarding kitchen and revealed: *The areas in the ser beverage station refe unchanged from the 3/19/24. *There was a cleanin by food service staff shift. -Those staff consiste students. *There was no clean service staff to comp	ation and interview on 30 a.m. and 11:40 a.m. with vice employee E in the aled: oor entrance was a tall, bx. ag inside of that box held od storage containers are opening of the box. are used by residents to a topened into the kitchen was a garbage can with a lid garbage can were kitchen towels on a cart. are used to wipe off wet meal a tiems during transport. Interview on 3/20/24 at 8:00 d food service employee E d dining area cleaning area cleaning area cleaning area cleaning checklist completed daily who worked the evening and of mostly high school and checklist form food	F8	12		
	what was expected to	o have been completed.				

	OF DEFICIENCIES F CORRECTION				X3) DATE SURVEY COMPLETED	
		435034	B. WING			C (2004
NAME OF D	ROVIDER OR SUPPLIER	430034	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2024
	ARYHOUSE LONG TERM	1 CARE		717 EAST DAKOTA PIERRE, SD 57501		
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F 812	Continued From page	2 7	F 8	312		
	and food services makitchen and beverage referred to above reverthe areas described dining areas were not manner. *There was currently completed evening cleompliancy. -The cleaning checkliand a day time cleaning be initiated. 6. Review of the revision Term Care) Food Saf Standard policy reveas standards of sanitation Nutrition Services Depersonnel, properly muncontaminated suppawareness, practice, sanitation and hygien Infection Prevention & CFR(s): 483.80(a)(1). §483.80 Infection Contraction prevention and designed to provide a comfortable environmed evelopment and trandiseases and infection program.	ealed: I above in the kitchen and It maintained in a sanitary no process for auditing the eaning checklists to ensure st might need re-evaluation ing checklist might need to sed March 2024 LTC (Long ety and Sanitation-System aled: "Maintaining high in and prevention infection in partment require health naintained equipment, slies and an ongoing and monitoring of proper e. " & Control (2)(4)(e)(f) Introl blish and maintain an ind control program i safe, sanitary and itent and to help prevent the insmission of communicable	F 8	The facility does ensure inf prevention and control pracare implented for proper disinfection of the rubber so an insulin vial and proper guse while completing a residence potentially at risk. No corrections could be done to resident 31 or 7	etices eal on love ident's ents	5/3/24

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ANDIEANO	OSIN LEGITOR		A. BUILDI	NG _		(o ::::	
		435034	B. WING			03/	21/2024	
	ROVIDER OR SUPPLIER ARYHOUSE LONG TERM	CARE		71	TREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST DAKOTA IERRE, SD 57501		. 14	
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F 880	and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable distaff, volunteers, visite providing services und arrangement based unconducted according accepted national state §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and transt to be followed to prevectively (iv) When and how iso resident; including but (A) The type and durate depending upon the ininvolved, and (B) A requirement that least restrictive possible circumstances. (v) The circumstances must prohibit employed disease or infected skeen contact with residents contact will transmit the staff of the system of the system.	IPCP) that must include, at ring elements: Im for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; Istandards, policies, and orgam, which must include, lance designed to identify le diseases or can spread to other In possible incidents of e or infections should be infections; lation should be used for a transition of the isolation, infectious agent or organism the isolation should be the ole for the resident under the isolations from direct or their food, if direct	F	880	The Director of Nursing will educate all nurses to ensure infection prevention and cont practices are being followed proper disinfection of the rubber seal on a resident's insulin vial before inserting the syringe needle and proper gluse during a resident's dress change. DON or designee will compled a audits/week X 4 weeks, the 4 audits/month X 3 months to ensure infection prevention a control practices are being followed. Results of the audits will be reported by the DON and discussed at the bi-monthly of meeting for further review an recommendations and/or continuation/discontinuation audits.	for ne ove ing ete en o ind		

Facility ID: 0019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE : COMPL	
		435034	B. WING_			03/2	21/2024
	ROVIDER OR SUPPLIER			71	REET ADDRESS, CITY, STATE, ZIP CODE 17 EAST DAKOTA IERRE, SD 57501	1 00.1	
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F 880	§483.80(a)(4) A systidentified under the force corrective actions takes §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual re The facility will condul PCP and update the This REQUIREMENT by: Based on observation and policy review, the infection prevention implemented for the *Disinfection of the resampled resident's (ilicensed practical nuinserting the syringe *Proper glove use do	em for recording incidents acility's IPCP and the sen by the facility. Idle, store, process, and se to prevent the spread of view. Luct an annual review of its eir program, as necessary. To is not met as evidenced on, interview, record review, e provider failed to ensure and control practices were following: Luct an annual review of its eir program, as necessary. To is not met as evidenced on, interview, record review, e provider failed to ensure and control practices were following: Luct an annual review of its eir program, as necessary.	F	380			
	a.m. with LPN H pre administration revea *Did not wipe the rul insulin vial with an a with a syringe. -Was expected to ha alcohol pad prior to p	ober seal on his Levemir Icohol pad before piercing it ave wiped the seal with an Diercing it.					
	12 Review of residen	it 7's electronic medical					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	C C
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F 880	record revealed: *His diagnoses includivenous insufficiency, chronic lower extrem *He developed an eignine-centimeter bliste that opened up on 2/-Dressing changes to daily and as needed. *Wound assessment foot as pink and mois clear drainage and not clear pair of gloved the chair the clifted the resider the resider the resider the resider the pad from the pad from the pad from the clear discarding the gloves, performed has pair of gloves and conchange. Interview on 3/19/24 after resident 7's dress	ded chronic peripheral chronic kidney disease, and ity edema. ght-centimeter by er on the top of his left foot 28/24. to that foot occurred twice s described the top of his sit with scant to moderate to signs of wound infection. 24 at 10:03 a.m. of LPN G 2's left foot dressing change that in a recliner in his and hygiene, put on a gown, toves then: tox sitting on top of the chair this recliner and moved it. box sat on out of the way. walker by its handles from in ed it. er gloves, performing hand on a clean pair of gloves she the top of his foot. pad she removed her and hygiene, put on a clean mpleted the dressing at 10:30 a.m. with LPN G essing change was completed	F 880		
	revealed she should performed hand hygi	have removed her gloves, ene, and put on a pair of ndling high-touch items like			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
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F 880	Continued From page		F8	80		
	before touching the V resident's foot.	the walker, and the sock aseline gauze pad on the at 11:00 a.m. with director of				
	nursing B and admini observations referred *Insulin preparation p disinfection of the rub	strator C regarding the to above revealed: tractices including ober seal of the insulin vial				
	of clean gloves after and before removing expected to mitigate	on practices. If hygiene, putting on a pair thandling high-touch surfaces resident 7's dressing was the risk of exposing				
	contaminants to the r	esident's opened skin on his				
	Injection Practices-M revealed: *"IV Frequently Asker Practices for Medical -A. 1. "b. Proper hand performed before har rubber septum should prior to piercing it."	d hygiene should be ndling medications and the d be disinfected with alcohol				
S .	(Long Term Care) Starevealed: "Gloves may need to of an individual paties -Gloves should be ch	anged after contact with a d before contact with a clean				

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E 000	CFR Part 482, Subpa Emergency Prepared Term Care facilities w through 3/21/24. Ave Care was found in co		E 00			4/9/24 (X6) DATE	
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		4/9/24	
	W41790.4	AND THE RESIDENCE OF THE PARTY		∆dministrator		413124	

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FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01	COMPLETED				
		435034	B. WING		03/19/2024				
	ROVIDER OR SUPPLIER	M CARE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)					
K 000	Life Safety Code (LS occupancy) was cor	vey for compliance with the SC) (2012 existing health care inducted on 3/19/24. Avera	−K 000						
SS=C	found not in compliar requirements for Lord requirements for Lord The building will me 2012 LSC for existing and the Fire Safety dated 3/20/24. Please mark an Fin for K226 deficiency FSES. The building will me 2012 LSC for existing upon correction of the K918 in conjunction commitment to continuous afety standards. Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if ur 7.2.4 and the provis 18.2.2.5.7, or 19.2.2.18.2.2.5, 19.2.2.5 This REQUIREMENT by: Based on observat	rm Care (Building 1) was ince with 42 CFR 483.90 (a) ing Term Care Facilities. et the requirements of the ing health care occupancies Evaluation System (FSES) the completion date column identified as meeting the et the requirements of the ing health care occupancies in deficiency identified at with the provider's inued compliance with the fire sed, are in accordance with the ions of 18.2.2.5.1 through 2.5.1 through 19.2.2.5.4.	K 226	TITLE	(X6) DATE				
Talli Da				Administrator	4/9/24				

Talli Raske 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 obcorrection 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 0019

If continuation sheet Page 1 of 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		435034	B. WING _			03/19/2024		
	ROVIDER OR SUPPLIER	M CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
K 226	ninety-minute horizo condition. The horizo building 1 and buildin when closed provide the door and the floor Findings include: 1. Observation and to p.m. revealed the crodoors separating bui second floor when cloninety-minute, fire-reassembly. The doors greater than 3/4-inch and the bottom of the indicates clearances 3/4-inch from the floor linterview with the suthe time of the above confirmed that finding been adjusted but ocatch on the floor the door were to cate prevent the automatifrom functioning. Resafety code survey dondition had existed construction. The deficiency affect.	e provider failed to maintain intal exit doors in operating ontal doors separating in 2 on the second floor a gap clearance between in greater than 3/4-inch. esting on 3/19/24 at 1:45 inchesses-corridor horizontal exit liding 1 and building 2 on the osed failed to maintain the sistive rating of the sewhen closed provide a gap in between the carpeted floor is door. NFPA 80 Article 3-6 is should be no greater than for to the bottom of the door. pervisor of facility services at the observation and testing in the indicated the door had build not be lowered any indoor further would cause it when in the open position. If it is on the floor it could it is self-closing mechanism wiew of the previous life ated 3/16/23 confirmed the distince the original	K 2	226				
	"F" in the completion	he FSES. Please mark an date column to indicate ciencies identified in K000.						

PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		435034	B. WING _			03/	19/2024
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	71 PI	TREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST DAKOTA ERRE, SD 57501 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	3E	(X5) COMPLETION DATE
K 918 K 918 SS=C	Electrical Systems - Electrica	Essential Electric System sting er alternate power source oment is capable of supplying onds. If the 10-second uring the monthly test, a rided to annually confirm this safety and critical branches. Iting of the generator and performed in accordance spected weekly, exercised as 12 times a year in 20-40 ercised once every 36 can bours. Scheduled test include a complete and automatic or manual ads, and are conducted by Maintenance and testing of sources (Type 3 EES) are in the A 111. Main and feeder an ally exercising the lished according to ments. Written records of ting are maintained and seedily identifiable, and I power circuits. Minimizing age of the emergency power ansideration for new	K 9	- 1	The facility does ensure to door generator battery conductivity monthly. All residents are potent at risk. The Administrator and or Facili Director will educate the Plant Technician to ensure to docum generator battery conductivity every month. The in-service we completed by 4/19/24. The Administrator or designee complete monthly audits X 4 m to ensure the above document logged appropriately. Results of the audits will be reposed by the Administrator or designed discussed at the bi-monthly Quanticus and the performance Impromeeting for further review and recommendations and/or continuation/discontinuation of	value entially ities Ops nent the value vill be will nonths ation is corted ee and vality vement	5/3/24

Facility ID: 0019

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		OATE SURVEY OMPLETED		
		435034	B. WING_			03/19/2024		
	ROVIDER OR SUPPLIER ARYHOUSE LONG TERN	I CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
K 918	Continued From page	3	KS	918				
	provider failed to docu conductivity value mo	ew and interview, the ument generator battery inthly (no documentation for otember 2023). Findings						
	battery conductivity in logs for the generator August, and Septemb 2023. Interview with t supervisor at 2:00 p.n monthly battery conductive mentioned mo	o documentation of the athe monthly maintenance of the monthly maintenance of the months of July, where for the calendar year the plant operations on 3/19/24 revealed the auctivity documentation ked as checked during the nother. He further stated on the						
	The deficiency affects occupants.	ed 100% of the building						

PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		1 ' '	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 02	2 - BUILDING 02		
		435034	B. WING			03/	19/2024
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AVERA MA	ARYHOUSE LONG TER	/ CARE			7 EAST DAKOTA ERRE, SD 57501		1.44
AVEIOTIB				P			(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
K 000	INITIAL COMMENTS	3	к	000			
	Life Safety Code (LS occupancy) was con- Maryhouse Long Ten found not in complian requirements for Lon	ey for compliance with the C) (2012 existing health care ducted on 3/19/24. Avera m Care (Building 2) was not with 42 CFR 483.90 (a) g Term Care Facilities.					
	2012 LSC for existing and the Fire Safety E dated 3/20/24. Please mark an F in	the completion date column eficiencies identified as					
K 226 SS=C	2012 LSC for existing upon correction of the K918 in conjunction commitment to continuately standards.	et the requirements of the g health care occupancies e deficiency identified at with the provider's nued compliance with the fire	К	226			F
	7.2.4 and the provisi	sed, are in accordance with ons of 18.2.2.5.1 through .5.1 through 19.2.2.5.4.					
	by:	T is not met as evidenced on, testing, interview, and					
LABORATORY		/SUPPLIER REPRESENTATIVE'S SIGNATURE			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 (Sep_Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of not be learned 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.

FORM CMS-2567(02-99) Previous Versions Obsol

Talli Raske

Event ID: XGEK21

Facility ID: 0019

If continuation sheet Page 1 of 5

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 2 - BUILDING 02	(X3) DATE SURVEY COMPLETED	
		435034	B. WING			03	/19/2024
	NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			7'	TREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST DAKOTA IERRE, SD 57501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 226	document review, the ninety-minute horizor condition. The horizor building 1 and buildin when closed provide the door and the floor Findings include: 1. Observation and te a.m. revealed the cro doors separating built second floor when cloninety-minute, fire-res assembly. The doors greater than 3/4-inch and the bottom of the indicates clearances: 3/4-inch from the floor. Interview with the sup the time of the above confirmed that finding been adjusted but confurther. Lowering the to catch on the floor with door were to catch prevent the automatic from functioning. Rev safety code survey decondition had existed construction. The deficiency affected requirements for fire-resulting meets the "F" in the completion of the condition of the completion of the compl	e provider failed to maintain stal exit doors in operating intal doors separating g 2 on the second floor a gap clearance between greater than 3/4-inch. Sesting on 3/19/24 at 10:30 iss-corridor horizontal exit ding 2 and building 1 on the osed failed to maintain the sistive rating of the when closed provide a gap between the carpeted floor door. NFPA 80 Article 3-6 ishould be no greater than in to the bottom of the door. Servisor of facility services at observation and testing in the indicated the door had all did not be lowered any door further would cause it when in the open position. If in on the floor it could it is self-closing mechanism flew of the previous life ated 3/16/23 confirmed the since the original	K	226			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02			(X3) DATE SURVEY COMPLETED			
		435034	B. WING			03/	19/2024
	IDER OR SUPPLIER	/ CARE		71	REET ADDRESS, CITY, STATE, ZIP CODE 7 EAST DAKOTA ERRE, SD 57501		R seed
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE
K 311 Ve SS=C CF Ve 20 Stash be ha An 19 If a co res bo Th by B: su ma stawii sa ha Th ree eg	afts, chutes, and of the tween floors are enving a fire resistance in atrium may be used. 3.1.1 through 19.3 all vertical openings instruction providing sistance rating, also existed an observation receiptain a protected air enclosure dischandow openings. Fire Observation on 3/1 exterior sidewalk air enclosure dischandow openings. Refety code survey code aurvey code air enclosure dischandow openings. Refety code survey code dexisted since the enclosure dischandow openings. Refety code survey code dexisted since the enclosure of the deficiency affects and existed since the enclosure of the completion date of the c	inclosure thafts, light and ventilation ther vertical openings inclosed with construction ce rating of at least 1 hour. ed in accordance with 8.6. 3.1.6 is are properly enclosed with g at least a 2-hour fire of check this is not met as evidenced in and review of previous ords, the provider failed to path of egress. The east arged past unprotected indings include: 19/24 at 1:15 p.m. revealed and steps from the east exit arged past unprotected eview of the previous life confirmed that the condition of original construction. ed one of numerous intaining protected paths of SES. Please mark an "F" in column to indicate correction	1	311 311			F
the sta will sa had The ree eg	e exterior sidewalk air enclosure dischandow openings. Refety code survey of a dexisted since the deficiency affects quirements for maingress. The building meets File completion date of the deficiencies idenjunction with the file.	and steps from the east exit arged past unprotected eview of the previous life onfirmed that the condition original construction. ed one of numerous intaining protected paths of SES. Please mark an "F" in column to indicate correction					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 02 - BUILDING 02

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

		435034	B. WING		03/19/2024
	ROVIDER OR SUPPLIER ARYHOUSE LONG TERN	I CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
K 311	standards.		K 3	11	F 10 10 4
K 918 SS=C	Electrical Systems - E Maintenance and Tes The generator or othe and associated equip service within 10 seco criterion is not met du process shall be prov capability for the life s Maintenance and test transfer switches are with NFPA 110. Generator sets are insunder load 30 minuted day intervals, and exe months for 4 continuo under load conditions simulated cold start a transfer of all EES loa competent personnel, stored energy power a accordance with NFP, circuit breakers are in program for periodica components is establi manufacturer requirer maintenance and test readily available. EES circuits are marked, re separate from normal the possibility of dama source is a design co- installations.	er alternate power source ment is capable of supplying onds. If the 10-second ring the monthly test, a ided to annually confirm this rafety and critical branches. ing of the generator and performed in accordance spected weekly, exercised as 12 times a year in 20-40 ercised once every 36 rus hours. Scheduled test include a complete and automatic or manual ruds, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder spected annually, and a lly exercising the ished according to ments. Written records of ing are maintained and power circuits. Minimizing age of the emergency power insideration for new	K 91	The facility does ensure to doc generator battery conductivity monthly. All residents are potent at risk. The administrator and or Facilit Director will educate the Plant Technician to ensure to docum generator battery conductivity every month. The in-service will complete by 4/19/24. The Administor or designee will complete monthly audits X 4 mill ensure the above documentation logged appropriately. Results of the audits will be reposed by the Administrator or designed discussed at teh bi-monthly QA meeting for further review and recommendations and/or continuation of audits.	value entially ties Ops ent the value ill be l onths to on is ported ee and API

PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - BUILDING 02		ATE SURVEY MPLETED
		435034	B. WING _			3/19/2024
	NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	DAKOTA	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 918	by: Based on record rev provider failed to do conductivity value m July, August, and Se include: 1. Record review on revealed there was r battery conductivity i logs for the generate August, and Septem 2023. Interview with supervisor at 2:00 p. monthly battery cond requirement was ma above-mentioned me months had the cond maintenance record	T is not met as evidenced view and interview, the cument generator battery onthly (no documentation for extember 2023). Findings 3/19/24 at 1:45 p.m. no documentation of the monthly maintenance or for the months of July, ber for the calendar year the plant operations m. on 3/19/24 revealed the ductivity documentation rked as checked during the onths. He further stated other ductivity value noted on the	K9	18		

Facility ID: 0019

PRINTED: 04/02/2024 FORM APPROVED OMB NO. 0938-0391

REGULTORY OR ISC IDENTIFYING INFORMATION) 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 311 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 of at least 1 hour. Fire resistance rating of the resistance r	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION IG 03 - BUILDING 03		(X3) DATE SURVEY COMPLETED	
AVERA MARYHOUSE LONG TERM CARE Mark D SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES D PREPRIX CROSS REFERENCE TO THE APPROPRIATE CROSS REFERENCE TO THE APPROP			435034	B. WING_		03	3/19/2024	
CAMPAIN CHAPTORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATE CONTROL OF TAG	NAME OF PROVIDER OR SUPPLIER				717 EAST DAKOTA		# * * * * * * * * * * * * * * * * * * *	
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. K311 K311 K311 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.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
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 311 Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stainways, 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 000	INITIAL COMMENTS		ΚC	000			
	K 311 SS=C	Life Safety Code (LSC occupancy) was cond Maryhouse Long Terr found not in complian requirements for Long The building will mee 2012 LSC for existing and the Fire Safety E dated 3/20/24. Please mark an F in t for K311 deficiencies FSES. The building will mee 2012 LSC for existing upon correction of the K918 in conjunction v commitment to continus afety standards. Vertical Openings - ECFR(s): NFPA 101 Vertical Openings - E2012 EXISTING Stairways, elevator si shafts, chutes, and of between floors are er having a fire resistand An atrium may be use 19.3.1.1 through 19.3 If all vertical openings construction providing resistance rating, also	C) (2012 existing health care ducted on 3/19/24. Avera in Care (Building 3) was ce with 42 CFR 483.90 (a) g Term Care Facilities. It the requirements of the health care occupancies valuation System (FSES) The completion date column identified as meeting the health care occupancies deficiency identified at with the provider's nued compliance with the fire inclosure Inclosure Inclosure Inclosure Inclosed with construction ce rating of at least 1 hour. Inclosed in accordance with 8.6. Inclosed with g at least 2-hour fire	KS	311		F	
	LABORATORY DI	IRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE				(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 institutions). Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not giplan 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XGER21

SD DOM-OLC

Facility ID: 0019

If continuation sheet Page 1 of 4

		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03		(X3) DATE SURVEY COMPLETED		
	435034	B. WING_	-7		03/	19/2024
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			71	7 EAST DAKOTA		
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
This REQUIREMENT by: Based on observation document review, the the one-hour, fire-resisthree stair enclosures activities room and the include: 1. Observation on 3/1 enclosures with doors their fire-resistive ratir 3/4-inch hollow metal located at the followin *To the stair enclosure room on the first and *To the stair enclosure on the first and second	n and previous survey provider failed to maintain stive rating for three of (north and east of the e southeast stairs). Findings 9/24 revealed three stair s without a label identifying ng. Those doors were 1 and doors. The doors were ng locations: es north of the activities second floors. es east of the activity room d floors.	K	3311			
dated 3/16/23 confirmexisted since the original confirmexisted since the original confirmexisted since the original confirments for fire-requirements for	and that the condition had inal construction. In do one of numerous stated door assemblies. SES. Please mark an "F" in column to indicate correction in the control of the condition in the con	ΚS	918	generator battery conductivity v monthly. All residents are poten	alue	5/3/24
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page This REQUIREMENT by: Based on observation document review, the the one-hour, fire-resi three stair enclosures activities room and the include: 1. Observation on 3/1 enclosures with doors their fire-resistive ratir 3/4-inch hollow metal located at the followin *To the stair enclosure on the first and second floors. Review of the previous dated 3/16/23 confirm existed since the origi The deficiency affects requirements for fire-re the completion date of the deficiencies ide conjunction with the fa continued compliance standards. Electrical Systems - E CFR(s): NFPA 101	ROVIDER OR SUPPLIER ARYHOUSE LONG TERM CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Electrical Systems - Essential Electric Syste	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03 - BUILDING 03 B. WING 435034 03/19/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 717 EAST DAKOTA AVERA MARYHOUSE LONG TERM CARE PIERRE, SD 57501 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The Administrator and or Facilities K 918 | Continued From page 2 K 918 Director will educate the Maintenance Maintenance and Testing Technician to ensure to document the The generator or other alternate power source generator battery conductivity value and associated equipment is capable of supplying every month when testing the service within 10 seconds. If the 10-second generator. The in-service will be criterion is not met during the monthly test, a completed by 4/19/24. process shall be provided to annually confirm this capability for the life safety and critical branches. The Administrator or designee will Maintenance and testing of the generator and complete monthly audits X 4 months transfer switches are performed in accordance to ensure the above documentation is with NFPA 110. logged and documented appropriately. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 Results of the audits will be reported day intervals, and exercised once every 36 by the Administrator or designee and months for 4 continuous hours. Scheduled test discussed at the bi-monthly QAPI under load conditions include a complete meeting for further review and simulated cold start and automatic or manual recommendations an/or continuation/ transfer of all EES loads, and are conducted by discontinuation of audits. 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 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

Facility ID: 0019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03			(X3) DATE SURVEY COMPLETED		
		435034	B. WING			03/19/2024		
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	HOULD BE COMPLÉTION		
K 918	battery conductivity in logs for the generator August, and Septemb 2023. Interview with the supervisor at 2:00 p.n monthly battery conductive requirement was mark above-mentioned moments had the conductive maintenance record for	b/19/24 at 1:45 p.m. of any documentation of the of the monthly maintenance for the months of July, where for the calendar year the plant operations in an 3/19/24 revealed the activity documentation ked as checked during the onths. He further stated on the	K 9	18				

South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 03/21/2024 10662 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 717 E DAKOTA AVERA MARYHOUSE LONG TERM CARE PIERRE, SD 57501 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 4/9/24 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. 4/9/24 S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/19/24 through 3/21/24. Avera Maryhouse Long Term Care was found in compliance.

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

TITLE

(X6) DATE

Talli Raske

STATE FORM

ENZ911

Administrator

4/9/24 If continuation sheet 1 of 1

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