

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2014
NAME OF PROVIDER OR SUPPLIER avera brady health and rehab			STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/7/14 through 10/9/14. Avera Brady Health and Rehab was found not in compliance with the following requirements: F221.	F 000	Addendums noted with an asterisk per 11/21/14 telephone to facilities interim administrator & DON. SD/DOH/ME	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Bed rail assessments had been completed for six of six sampled residents (4, 5, 7, 8, 9, and 11) with bed rails. *Bed rails had been care planned for two of six sampled residents (4 and 9) with bed rails. Findings include: 1. Observation of resident 5's bed revealed one bed rail attached to the upper half of the bed located closest to the center of the room. Review of resident 5's medical record revealed: *She had been admitted on 8/1/14. *The 8/1/14 care plan had indicated: -She had required some assistance with repositioning. -She was to have used a UBAR (a positioning bar	F 221	1. Corrective action for each finding a. Side rail use assessments were completed by Clinical Coordinators on all residents currently using side rails to be sure they were appropriate. Physician's orders were obtained and care plans were updated. If side rail was determined to be inappropriate they were removed. Care plans were updated. *Side rails were removed for residents 5, 7 & 8. SD/DOH/ME 2. Changes made to the system a. Prior to side rails being utilized for any other resident the charge nurse will complete the side rail use assessment form. The form will then be given to Clinical Coordinators for evaluation. If determined appropriate by Clinical Coordinators, nursing will obtain a physician order, care plan the side rail and the maintenance department will be notified to apply the side rail. These *including residents 4, 5, 6, 7, 8, 9 and 11. SD/DOH/ME *for all residents including residents 4 and 9. SD/DOH/ME	

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

TITLE

(X6) DATE

Julie Hoffmann

Interim Administrator

11/5/14

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 114 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301	
(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 221	<p>Continued From page 1</p> <p>to assist with repositioning) for positioning in bed. *No initial bed rail assessment had been located.</p> <p>2. Observation of resident 8's bed revealed one bed rail attached to the upper half of the bed located closest to the center of the room. Review of her medical record revealed: *The 9/10/14 care plan indicated: -She had been admitted 10/1/12. -She had required some assistance with repositioning. -She was to have used one UBAR for positioning in bed. *No initial bed rail assessment or periodic reassessments had been located.</p> <p>Interview on 10/8/14 at 1:30 p.m. with registered nurse (RN)/clinical coordinator A regarding bed rails for residents 5 and 8 revealed: *She had reviewed the resident's use of the bed rails with each Minimum Data Set (MDS), but had not formally assessed for the appropriateness of the bed rail. *No initial bed rail assessment had been located to show the bed rails had been appropriate for use prior to placing them on the residents' beds.</p> <p>Surveyor: 34030 3. Random observations from 10/7/14 to 10/9/14 of resident 9's bed revealed two positioning bars in the up position at the top of her bed.</p> <p>Interview on 10/8/14 at 2:00 p.m. with resident 9 revealed she used the positioning bars to move herself in bed.</p>	F 221	<p>side rail assessments will be updated quarterly or during a significant change with the residents' MDS. In-service was completed 11/4/14 by DON/Administrator for all staff regarding restraints and side rails.*</p> <p>3. Monitoring performance a. Use of side rails will be assessed initially and then quarterly (when) by the Clinical Coordinators (who) to ensure the assessment was completed, a physicians order was obtained, and the side rail was care planned (what). Clinical coordinators will report this information to the Administrative/QI team quarterly X 1 year.</p> <p>4. Anticipated Correction date a. 11/4/14</p> <p><i>* 3 months x 3 months SD/SD/04/MF</i></p> <p><i>The side rail policy was developed and implemented to reflect above changes. SD/SD/04/MF</i></p>	11/4/14

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

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F 221	<p>Continued From page 2</p> <p>Review of resident 9's medical record and care plan dated 9/9/14 revealed: *An admission date of 9/9/14 for rehabilitation due to a fall with a fractured left ankle. *The positioning bars had not been assessed for appropriateness of use nor placed on the care plan.</p> <p>4. Random observations on 10/8/14 of resident 11's bed revealed one positioning bar in the up position at the top of her bed.</p> <p>Review of resident 11's medical record and care plan dated 9/25/14 revealed: *An admission date of 2/3/11. *Diagnoses that included end stage kidney disease and muscle weakness. **"U-bar (positioning bar) Rt. side of bed" on the care plan. *No initial or ongoing assessments for the appropriateness of use had been done on the positioning bar.</p> <p>Surveyor: 32331</p> <p>5. Observation on 10/7/14 at 8:00 a.m. revealed resident 7's bed had two positioning bars up on both sides of the top half of his bed.</p> <p>Review of resident 7's medical record revealed: *No assessment had been completed for the use of the positioning bars. *There were no physician's order for those positioning bars.</p> <p>Review of the provider's 7/2/14 OT (occupational therapy) Interim Progress Note revealed resident 7 had been "utilizing grab rail."</p>	F 221			

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F 221	<p>Continued From page 3</p> <p>Review of the provider's 9/23/14 care plan for resident 7 revealed he used a UBAR on both sides of his bed for positioning.</p> <p>Interview on 10/7/14 at 10:00 a.m. with registered nurse A regarding positioning bars on resident 7's bed revealed: *Positioning bars were not being assessed. *No assessments were being done on positioning bars. *She was not aware all positioning bars needed to have been assessed. *She was unsure of how long the positioning bars had been on his bed. *She agreed positioning bars needed to have been periodically assessed for his safety.</p> <p>6. Observation on 10/7/14 at 11:00 a.m. revealed resident 4's bed had two positioning bars up on both sides of the top half of his bed.</p> <p>Review of resident 4's medical record revealed: *No assessment had been completed for the use of the positioning bars. *There were no physician's order for those positioning bars.</p> <p>Review of the provider's 8/14/14 care plan for resident 4 revealed there was no documentation regarding the usage of the positioning bars on his bed.</p> <p>Interview on 10/7/14 at 10:10 a.m. with RN F regarding positioning bars on resident 4's bed revealed: *Positioning bars were not being assessed. *No assessments were being done on positioning bars.</p>	F 221			

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NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301		
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F 221	<p>Continued From page 4</p> <p>*She was not aware all positioning bars needed to have been assessed.</p> <p>*She agreed positioning bars needed to have been periodically assessed for his safety.</p> <p>7. Interview on 10/7/14 at 9:45 a.m. with the director of nursing (DON) revealed no assessments were being done on positioning bars as they had not been considered as a possible restraint.</p> <p>Review of the provider's revised June 2009 Restraint Reduction policy revealed: *Interventions would have been put into place to prevent, reduce, and/or eliminate the use of restraints whenever possible. *A physical restraint elimination assessment was to have been completed at least quarterly. *The resident's environment would be fully assessed for any safety hazards.</p> <p>Review of the provider's revised December 2003 Restraint Information for Resident/Family policy revealed: *Restraints had included full, three quarter, half side rails, and waist safety devices. *The policy had not specified positioning bars as a restraint.</p>	F 221			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2014
NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301	
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/7/14. Avera Brady Health and Rehab (original building) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 10/7/14 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain a one hour fire rated path of egress from the basement and the	K 033		

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

TITLE

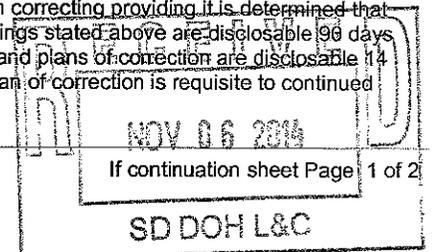
(X6) DATE

Julie Hoffmann

Interim Administrator

11/5/14

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



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K 033	<p>Continued From page 1</p> <p>second floor to the main level service area exterior of the building. Four randomly observed stairs from the basement and the second floor discharged onto the main level of the building. Findings include:</p> <p>1. Observation at 11:00 a.m. on 10/7/14 revealed the basement and second floor stairs discharged into the main level corridor system. A continuous one hour fire rated protected path of egress was not maintained to the exterior of the building. Review of the previous life safety code survey on 7/30/13 confirmed those findings.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 033		F

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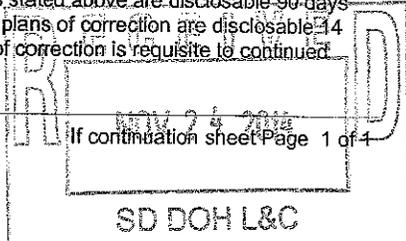
NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/7/14. Avera Brady Health and Rehab (Center Addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie Hoffmann</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/19/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 10/7/14. Avera Brady Health and Rehab (North Addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie Hoffmann</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/19/14</i>
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NOV 24 2014
SD DOH L&C
If continuation sheet Page 1 of 1

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2014
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NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301
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S 000	Initial Comments Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/7/14 through 10/9/14. Avera Brady Health and Rehab was found not in compliance with the following requirement: S166.	S 000	<i>Addendums noted with an asterisk per 11/21/14 telephone to facilities interim administrator and DON. SB/SDDCH/MF</i>	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166	<ol style="list-style-type: none"> 1. Corrective action for each finding <ol style="list-style-type: none"> a. All exit doors will be alarmed or manned so that staff will be alerted when a resident leaves the building. 2. Changes made to the system <ol style="list-style-type: none"> a. All exit doors will be alarmed or manned so that staff will be alerted when a resident leaves the building. In-service was completed for all staff on 11/4/14 regarding the alarms. b. Wanderguard bracelets will still be applied to those found to be at risk for elopement. 3. Monitoring performance <ol style="list-style-type: none"> a. Maintenance (who) will do weekly checks (when) of all the exit door locks/alarms (what) to be sure they are in working order and record it on the planned maintenance log. These checks will be reported to the Administrative/QI team quarterly X 1 year. (how) 4. Anticipated Correction date <ol style="list-style-type: none"> a. 11/4/14 	<i>*11/4/14 SB/SDDCH/MF</i>

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

Julie Hoffmann

TITLE

Interim Administrator

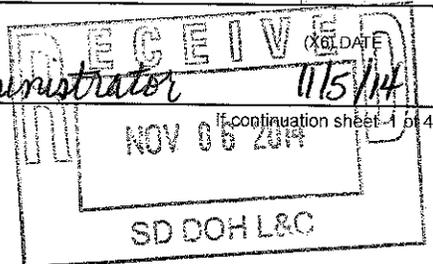
(X6) DATE

11/5/14

STATE FORM

6899

7X9X11



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2014
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NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301
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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to ensure 10 of 12 exit door alarms (Vasek main and east, Brooklane east, maintenance delivery, back hall courtyard, administration offices, front main, Harmony, pub, and chapel hall): *Were activated when unattended. *Had not automatically silenced when the door closed. Findings include:</p> <p>1. Observations throughout the survey from 10/7/14 through 10/9/14 revealed on 10/7/14 from 2:00 p.m. until 2:30 p.m.: *The exit door off the chapel had been unlocked, unattended, and unalarmed. *The Harmony exit door had been unlocked, unattended, and unalarmed. *The pub exit door had been unlocked, unattended, and unalarmed. *Interview at that time with the social services</p>	S 166		

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301
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(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
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S 166	<p>Continued From page 2</p> <p>designee and the administrator revealed: -The pub door was usually locked unless there had been an activity in the courtyard. *Residents and family used those doors to enter and exit the building. *The provider had attempted to lock the doors, but staff became used to the alarm. Staff stopped checking to see who exited, because the alarm sounded so often. *All exit doors were locked at some point in the evening. -Some of the doors locked automatically. -Some doors required a staff member to lock them. -She was not sure which doors had required a staff member to manually lock them. -The above doors had a Wanderguard alarm, so if a resident was wearing a Wanderguard bracelet the door would alarm if someone exited. -The above doors would not alarm if a resident exited who had not worn a Wanderguard bracelet. *When asked how staff would be able to tell a resident had not suddenly become confused and would have left the building, she stated the staff would observe each resident for changes.</p> <p>Interview on 10/8/14 at 10:15 a.m. while on tour with the maintenance supervisor revealed: *All exit doors were alarmed with a Wanderguard system. *The system only alarmed for those residents with a Wanderguard bracelet. *The main entrances of the Vasek unit and the original front entrance were attended during the day hours. *The above door alarms would remain alarming until they were manually shut off. *The other exit doors were not consistently attended or alarmed but remained open during</p>	S 166		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2014
NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301		
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S 166	<p>Continued From page 3</p> <p>the day hours.</p> <p>Observation of the main entrance while the surveyors exited the building on 10/8/14 at 6:45 p.m. and on 10/9/14 at 5:15 p.m. revealed the doors were unlocked, unattended, and unalarmed.</p> <p>Review of the provider's February 2013 Locking of Entrance/Exit Doors policy revealed: *"It is necessary to have established schedules for locking the facilities' entrances and exits to secure protection for patients, relatives, personnel and property." *(The provider) "lock the Main Drives entrance, the main Lanes entrance, and the chapel entrance at 8:00 p.m. and opens them at 5:00 a.m." *"The Maintenance Shop entrance is locked at 5:00 p.m. and unlocked at 5:00 a.m." *No other exit doors had been mentioned in the policy.</p>	S 166		