

SOUTH DAKOTA DEPARTMENT OF HEALTH

ORIGINAL

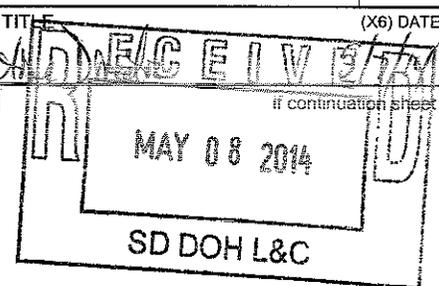
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10662</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>AVERA MARYHOUSE LONG TERM CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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S 000	Initial Comments  Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/07/14 through 4/09/14. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: S121 and S236.	S 000	Addendums noted with an asterisk per 6/19/14 telephone to facility Dir. mpj@ddoh/mf	
S 121	44:04:02:02 Sanitation  The facility must be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases to residents,...personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation.  This Rule is not met as evidenced by: Surveyor: 18087 Based on random observation and interview, the provider failed to maintain walls in a cleanable condition. The north wall of the 2nd floor housekeeping room had an opening in the gypsum board wall approximately 25 square inches in area. Findings include:  1. Random observation from 10:00 a.m. to 4:00 p.m. on 4/08/14 revealed the north wall of the 2nd floor housekeeping room of Building 01 had an opening in the gypsum board wall approximately 25 square inches in area just above the mopboard height. Interview with the plant operations director at the time of the observation confirmed that finding. He stated that	S 121	Addendums noted with a double asterisk per 6/19/14 telephone to facility plant operations Director. chkd@ddoh/mf  *The director of plant operations will report to the quality improvement committee (aic) quarterly. This reporting will continue until the aic advises to discontinue. mpj@ddoh/mf Maintenance Staff will install a kick plate to cover the opening and guard against future damage by carts.	5/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. Schmidt</i>	TITLE Executive Director	(X6) DATE
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S 121

Continued From Page 1  
  
a kickboard would need to be added to that portion of the wall.

S 121

*\*\* The Plant Operations Director will monitor the correction of this item and will report its completion to the QA committee. CHISBOOTHIME*

S 236

44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  
  
Tuberculin screening requirements for healthcare workers or residents are as follows:  
  
(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  
  
This Rule is not met as evidenced by:  
Surveyor: 23059  
  
Surveyor: 32572  
Based on record review and interview, the provider failed to implement the Tuberculin program as their policy directed for 3 of 13 sampled residents (4, 10, and 12). Findings include:  
  
1. Review of resident 4's Resident Skin Testing and Evaluation Record revealed she had been admitted to the facility on 5/31/13. Her initial

S 236

*1. Corrective actions include:  
Residents 4, 10 + 12 will have a 2-step mantoux skin test completed and documented by 5-22-14. \* See page 3 mpsidohime  
A monitoring tool will be completed by a ward clerk, RN, or LPN. The staff member performing the monitor will check the Resident Skin Testing and Evaluation Record. [redacted] \* mpsidohime  
[redacted] \* If a 2-step Mantoux test was not completed it will be started the day it was found. Once all current facility residents records have been reviewed the number of monitors will be decreased to the number of new admits to the facility the previous month. The monitoring tools will be submitted by the*

*5/29/14*

*See page 3 mpsidohime*

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S 236	Continued From Page 2  tuberculin skin test had been administered on 6/1/13 and read on 6/3/13. No second tuberculin skin test had been completed.  2. Review of resident 10's medical record revealed she had been admitted on 6/3/14. *The Resident Skin Testing and Evaluation Record revealed she had been given the initial skin test on 4/6/13 and read on 4/6/13. *The second skin test had been given on 4/19/13 and read on 4/22/13 with no indication of results documented. *The resident's June 2013 medication administration record (MAR) indicated the tuberculin testing had occurred on 6/4/13 and 6/19/13.  3. Review of resident 12's medical record revealed he had been admitted on 7/15/13. *He had been allergic to the tuberculin skin test. *He had not had a chest x-ray (CXR) to indicate he had been free from the tuberculin communicable disease.  4. Interview on 4/9/14 at 9:00 a.m. with the infection control nurse confirmed tuberculin testing should have occurred within the first ten to fourteen days of admission. If a resident was allergic to the testing agent a CXR should have been obtained with the findings indicating the resident had been free from the tuberculin communicable disease.  Review of the provider's revised February 2014 Tuberculin Screening Requirements for Patient/Residents revealed: *The purpose had been "To determine the presence or absence of active Mycobacterium Tuberculosis, and prevent transmission of the disease." **"Every attempt must be made to ensure that	S 236	<i>DON to The Quality Improvement Committee (QIC) quarterly starting in May, 2014. This will be continued quarterly until the elect. QIC advises to discontinue.</i>  <i>* Education was completed to ensure the tuberculin skin testing will be done in a timely manner. This education was done with the DON, ADON and MDS coordinators on 05/06/14. mp/sddoh/mf</i>  <i>*All current residents will be reviewed for a 2-step mantoux test by 05/09/14. mp/sddoh/mf</i>	

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S 236	Continued From Page 3  each new patient/resident of TCU/Mary House receives the two-step method of Mantoux skin test within 14 days of admission, unless there is documentation of a previous positive reaction (10 mm [millimeters] or greater)."	S 236		

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F 000	INITIAL COMMENTS  Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 04/07/14 through 04/09/14. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F281, F371, and F441.	F 000	Addendums noted with an asterisk per 05/19/14 telephone to facility DON. mpj/sddoh/mf	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Signed physicians' orders had been clarified to include the appropriate dose of medications for 13 of 13 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13). *Accurate weights had been documented for 3 of 13 sampled residents (1, 3, and 4 ). *Oxygen administration had been safely provided for 1 randomly observed resident in the beauty salon. *Schedule II narcotic patches had been disposed of appropriately for 2 randomly reviewed residents (19 and 20). Findings include:  1. Review of residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13's medical records revealed they all had contained signed LTC (long-term care)	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Mark C Schmidt</i>	TITLE  <i>Executive Director</i>	(X6) DATE  <i>5/7/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1 Physician Order Sheets. *There had been multiple incomplete medication orders on those order sheets that included: -Missing units of measurement such as milligrams, drops, and milliliters. -Dosage strength such as how many tablets or the total dosage to be given. -Medication frequency such as once a day, three times a day, or four times a day as needed.</p> <p>Interview on 4/8/14 at 1:00 p.m. with the director of nursing (DON) and assistant director of nursing (ADON) confirmed the physicians' orders for the above residents contained incomplete orders. The provider had implemented that system in November 2013. Nurses were not able to compare medications with those signed order sheets.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 847, revealed "The components of a medication order are, resident's name, date the order is written, the medication name, dose, route of administration, along with the time and frequency of administration and the signature."</p> <p>2. Review of resident 1's complete medical record revealed: *Multiple diagnoses including diabetes mellitus type II, chronic kidney disease, peripheral vascular disease, and edema. *A 10/29/13 physician's order for Lasix 20 milligrams daily. *Fluctuating weights as follows: 1/26/14, 280 pounds (lb); 1/29/14, 261 lb; 2/2/14, 258.6 lbs; 2/5/14, 292 lbs; 3/12/14, 246.5 lb; 3/19/14, 266.5 lb; 3/23/14, 285 lb; 3/26/14, 277.5 lb.</p>	F 281	<p>1. Corrective actions include: Internet Technologists (IT) have made improvements in our electronic medical record system and will continue making improvements to include units of measurement, dosage strength, and medication frequency in our physician orders so that nurses are able to compare medications with the signed physician orders. IT will continue to make improvements until all physicians' orders are complete. Until this process is finalized, the physicians' order sheets will be reviewed and completed by the Assistant Director of Nursing (ADON) or Minimum Data Set (MDS) nurses prior to physicians reviewing and signing orders. Compliance with ensuring that all physician order sheets are complete prior to physicians</p>	<p>5/29/14</p> <p>*see page 2nd MDS/MDM</p>
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F 281	<p>Continued From page 1 Physician Order Sheets. *There had been multiple incomplete medication orders on those order sheets that included: -Missing units of measurement such as milligrams, drops, and milliliters. -Dosage strength such as how many tablets or the total dosage to be given. -Medication frequency such as once a day, three times a day, or four times a day as needed.</p> <p>Interview on 4/8/14 at 1:00 p.m. with the director of nursing (DON) and assistant director of nursing (ADON) confirmed the physicians' orders for the above residents contained incomplete orders. The provider had implemented that system in November 2013. Nurses were not able to compare medications with those signed order sheets.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 847, revealed "The components of a medication order are, resident's name, date the order is written, the medication name, dose, route of administration, along with the time and frequency of administration and the signature."</p> <p>2. Review of resident 1's complete medical record revealed: *Multiple diagnoses including diabetes mellitus type II, chronic kidney disease, peripheral vascular disease, and edema. *A 10/29/13 physician's order for Lasix 20 milligrams daily. *Fluctuating weights as follows: 1/26/14, 280 pounds (lb); 1/29/14, 261 lb; 2/2/14, 258.6 lbs; 2/5/14, 292 lbs; 3/12/14, 246.5 lb; 3/19/14, 266.5 lb; 3/23/14, 285 lb; 3/26/14, 277.5 lb.</p>	F 281	*This includes record reviews for residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13. mps/DDH/MF	

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F 281	<p>Continued From page 2</p> <p>*No re-weighs had been done for the above listed weights.</p> <p>*A 3/17/14 care plan evaluation identified the scales accuracy as being a possible contributing factor for the difference in weights.</p> <p>3. Review of resident 4's 11/11/13 through 3/26/14 weight record revealed: *On 12/1/13 her weight was documented as 141.2 lb. *On 12/4/13 her weight had been documented as 150 lb. -There was no re-weight or explanation as to the nearly 9 lb. wt. gain. *On 3/8/14 her weight was documented as 141.4 lb. *On 3/12/14 her weight was documented as 122.4 lb. *On 3/23/14 her weight was documented as 142. lb. -There was no re-weight or explanation as to the 19 lb. wt. loss and subsequent 20 lb weight gain.</p> <p>4. Review of resident 3's complete medical record revealed: *On 2/10/14 he had weighed 117.5 lb. *On 2/13/14 he had weighed 75.5 lb. -There had been a notation entered by CNA C that had stated "The scale might be off and needs reweight." -There had not been a reweight documented. *On 2/17/14 he had weighed 114.5 lb. *On 2/20/14 he had weighed 117.5 lb.</p> <p>5. Interview on 4/8/14 at 3:00 p.m. with the ADON revealed: *Inaccurate weights had been identified as a problem area. *She would have expected certified nursing</p>	F 281	<p><i>signing orders will be monitored by the Director of Nursing (DON) who will complete a monitoring tool 12 times monthly. The monitoring tools will be submitted by the DON to the Quality Improvement Committee (QIC) quarterly starting in May, 2014. This will be continued quarterly until the electronic medical record improvement process is completed and the QIC advises to discontinue.</i></p> <p><i>2. Corrective actions for inaccurate weights include: Establishing a baseline weight for residents 1, 3, and 4 by weighing them each on a consistent scale for at least 3 consecutive days until the weights are within a 5 pound range. Thereafter, these residents and all other residents will be weighed on a consistent scale, by a consistent staff member or their</i></p>	<p><i>*MPL/SD/HTM</i></p>
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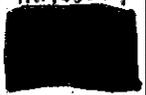
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F 281	<p>Continued From page 3</p> <p>assistants (CNA) to re-weigh and notify the charge nurse if there was a five pound fluctuation in residents' weights.</p> <p>*Resident 1's weights were inaccurate, and she would not feel comfortable showing them to his physician.</p> <p>*The scale had been inaccurate.</p> <p>Interview on 4/9/14 at 10:30 a.m. with the assistant director or nursing revealed CNAs had access to the weight spreadsheets. It would have been her expectation the CNAs review that information when entering a weight to compare the weights taken. If there had been a difference of five pounds or greater, the resident should have been re-weighed. If the weight remained the same, that should have been reported to the charge nurse. She confirmed there was no way to know if the above weight discrepancies had been due to keystroke error, faulty scale, or was an accurate weight.</p> <p>Review of the provider's revised 7/10/12 Height Measuring and Weight Monitoring-Nursing Services policy revealed "CNAs will weigh residents/patients weekly &amp; report weights to the charge nurse on duty."</p> <p>6a. Review of resident 19's Controlled Substances Inventory sheets for her Fentanyl patch revealed it had been documented as disposed of on 3/22/14 and 4/6/14 by two unlicensed assistive personnel (UAP).</p> <p>b. Review of resident 20's Controlled Substances Inventory sheet for his Fentanyl patch revealed it had been documented as disposed of on 3/22/14 and 4/6/14 by two UAPs.</p>	F 281	<p><i>designee and entered into the electronic medical record by that staff member or their designee. Fluctuations of 5 pounds or more will warrant a reweigh and these weights, if they are 5 pounds or more, will be reported to the ADON and MDs Nurses. The ADON and MDs Nurses will report weight fluctuations to the dietician and physician for the residents involved. To ensure all residents in the facility have an established baseline weight, the ADON and MDs Nurses will review all residents' weights on a newly established Clinical Intelligence Long Term Care Weight Management Program Report. If no baseline has been established a consistent staff member will weigh the resident at least 3 consecutive days until the weights are within a 5 pound range. Compliance with ensuring that all residents who have a 5 pound or more variance have</i></p>	
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
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F 281	<p>Continued From page 4</p> <p>c. Interview on 4/9/14 at 11:25 a.m. with the DON revealed at least one person disposing of a Fentanyl patch should have been a licensed nurse. Two UAPs should not have documented the disposal of a schedule II narcotic medication.</p> <p>Review of the provider's 3/11/14 Controlled Substance Administration, Control, and Accountability policy revealed "Upon removal of an old narcotic patch, it must be witnessed by two staff members (at least one who is licensed) to validate that the old patch was located, and then with both staff present the old patch is to be flushed in the toilet..."</p> <p>7. Observation and interview on 4/9/14 at 2:10 p.m. of the beautician and a random resident while they had been leaving the beauty shop and entering the elevator revealed: *The beautician held the resident's oxygen tubing in her hand. *The resident had an oxygen cannula in her nose. *The beautician stated she disconnected the resident's oxygen when she assisted her to the beauty shop. She looked to see where the oxygen was set at her room. When they arrived in the beauty shop she connected the resident's oxygen tubing and turned it on. She stated she set the oxygen for what it was at in her room. She denied having any training in oxygen use or how to set it. She stated she did this for all residents with oxygen that came to the beauty shop.</p> <p>Interview on 4/9/14 at 2:40 p.m. with the DON confirmed the beautician had not been educated to set the oxygen liter flow for the residents. She had been unaware the beautician had been doing that. She agreed it was not acceptable for the beautician to set the liter flow of oxygen.</p>	F 281	<p><i>been reported to the ADON and MDS Nurses will be accomplished by reviewing the Clinical Intelligence Long Term Care Weight Management Program Report every two weeks. The results of these reports being reviewed by the ADON and MDS Nurses will be submitted to the QIC by the DON quarterly starting in May, 2014 and will continue until the QIC advises to discontinue.</i></p> <p><i>3. Corrective actions for narcotic patch disposal include: Nurses and Medication Administration Technicians (MATs) were provided education from Policy 6312.72 Controlled Substance Administration, Control, and Accountability concerning the correct disposal of controlled substances which includes being witnessed and signed by at least one licensed staff member. The MATs who disposed of controlled substance</i></p>	

*\*IMP/RODD/HMF*  


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
(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 281	Continued From page 5  Surveyor: 32333  Surveyor: 29162  Surveyor: 32572	F 281	<p><i>patches improperly were also given one on one education on the proper disposal of controlled substances by the DON. Compliance with MATS disposing of controlled substances including patches will be monitored by RNs and LPNs delegated to complete a monitoring tool that will indicate if controlled substances are disposed of properly. 12 monitoring tools will be completed monthly and reported to the DON. The DON will submit the results of these monitoring tools to the QIC quarterly starting in May, 2014 and will continue until the QIC advises to discontinue.</i></p> <p><i>F281 <del>is</del> Corrective actions for O2 Concentrator use in beauty shop include: Effective immediately as of 5/1/14 the O2 Concentrator was removed from the beauty shop and policy will be changed to have nursing staff bring</i></p>	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure ready-to-eat food was served in a sanitary manner during two of two observed meal services by two of three food and nutrition aides (A and B). Findings include:  1. Observation on 4/7/14 from 4:30 p.m. through 5:30 p.m. of food and nutrition aide A revealed he made two slices of toast and two chicken salad sandwiches. While he prepared those food items he had on gloves. While wearing those gloves he touched multiple surfaces that included the	F 371		

*\*see page 60  
M/S/D/1/1/14*

*5/29/14*

*UA*

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
(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 281	Continued From page 5	F 281	*This included education for the disposal of the medicated patches for residents 19 and 20. mp/sddoh/mf	
F 371 SS=D	Surveyor: 32333 Surveyor: 29162 Surveyor: 32572 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure ready-to-eat food was served in a sanitary manner during two of two observed meal services by two of three food and nutrition aides (A and B). Findings include:  1. Observation on 4/7/14 from 4:30 p.m. through 5:30 p.m. of food and nutrition aide A revealed he made two slices of toast and two chicken salad sandwiches. While he prepared those food items he had on gloves. While wearing those gloves he touched multiple surfaces that included the	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
(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 371	Continued From page 6 counter, bread bag, serving utensils, jelly and margarine containers, chicken salad container, toaster, and plates. While he had on those same gloves he touched the ready-to-eat bread he used to make toast and sandwiches.  Observation on 4/8/14 from 10:20 a.m. through 10:50 a.m. of food and nutrition aide B while she served the morning brunch revealed she had on gloves. While she wore those gloves she touched multiple items that included serving utensils, plates, counters, and resident's menus. She served ready-to eat pancakes onto the plates that were served to the residents. She did not use a utensil to serve those pancakes. She served them with her gloved fingers.  Interview on 4/9/14 at 9:30 a.m. with the director of food and nutrition services confirmed food and nutrition aides A and B had not served ready-to-eat food in a sanitary manner. He stated utensils should have been used to prepare and serve the ready-to-eat bread and pancakes.  Review of the provider's last reviewed 8/9/11 Handling Ready to Eat Foods policy revealed: *Improper handling of ready-to-eat food could cause the individuals who had consumed it to become ill. *If gloves became contaminated new gloves were to have been obtained and put on after proper handwashing had occurred.	F 371	<i>the residents' O2 concentrators from their rooms as necessary which will allow residents to remain on un-adjusted flow and will use personal supplies. The Activities Coordinator will monitor weekly to ensure policy is met and she will report to the QIC quarterly starting in May, 2014. This will continue until the QIC advises to discontinue</i>	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	<i>B71 1. Corrective actions for handling ready to eat foods and proper handwashing includes: Education was provided to staff in the dietary department and the nursing staff on the proper handling of food and handwashing procedures. This included the use of gloves. Compliance with this education will be the monitoring of each meal a minimum of 2 times per week. The Hand washing audit will be</i>	<i>5/29/14</i>

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
(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)
F 441	<p>Continued From page 7 to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to maintain numerous</p>	F 441	<p><i>done in the dietary department and the nursing facility a minimum of 5 times per week. These will be performed by the supervisor / Department Director or Chef. These monitors will be submitted to the Director of Dietary Services monthly and he will submit quarterly to the QIC starting in May, 2014. These will continue until the QIC advises to discontinue.</i></p>

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NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
(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)
F 441	<p>Continued From page 8</p> <p>surfaces and areas throughout the building in a sanitary manner for the following.</p> <p>*In the restorative area three of four NuSteps (exercise bike) had foam on the lower bars that had chipped areas or foam missing making uncleanable surfaces.</p> <p>*Two of two oxygen concentrators in the dining room and one of one oxygen concentrator in the activity room had dirty filters.</p> <p>*Towels laying on the floor in the mechanical room on second floor during random observations on three of three days of the survey.</p> <p>*Wooden table surfaces in the solariums on first and third floors had areas where the finish had been worn off creating uncleanable surfaces.</p> <p>*On the third floor one of three recliners had been placed on wooden blocks which were not finished creating uncleanable surfaces.</p> <p>*Oxygen had been used in a safe and sanitary manner in the beauty shop.</p> <p>*The scissors, comb, and curlers used by the beautician were disinfected between resident use.</p> <p>Findings include:</p> <p>1. Random observations from 4/7/14 through 4/9/14 revealed:</p> <p>*The NuStep machines in the restorative area had pieces of foam on the lower bars that had large gouges or missing pieces (photo 1).</p> <p>*Oxygen concentrators that were stored in the dining room and used at meal times had gray and brown colored residue on the filters. The concentrator that had been stored in the activity room also had gray and brown residue on the filter (photo 2).</p> <p>*During random observations there had been white towels laying on the floor in the mechanical room on third floor (photo 3).</p>	F 441	<p><i>F441 1. The items identified on the Nu-Step were replaced with new, cleanable parts.</i></p> <p><i>2. O2 concentrator filters will be cleaned by Resident Assistants monthly throughout the facility.</i></p> <p><i>3. Staff were educated not to leave towels lying around. They go in the soiled linen room.</i></p> <p><i>4. Wood table surfaces were repaired or repainted to ensure they were cleanable surfaces. Staff were educated about cleanable surfaces.</i></p> <p><i>Other areas were reviewed for non cleanable surfaces. Maintenance staff will complete monthly rounding for these surfaces and report any items to the Maintenance supervisor. These 4 bullet items will be monitored monthly and report to the QTC quarterly.</i></p> <p><i>5/29/14</i></p>

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F 441	<p>Continued From page 9</p> <p>*In first and third floor the solariums there had been wooden tables with several areas where the finish had been worn off creating an uncleanable surfaces (photos 4, 5, and 6). *On the third floor there had been recliners placed by the television. One of the recliners had been placed on wooden blocks that had not been finished creating uncleanable surfaces (photo 7).</p> <p>Interview on 4/9/14 at 9:00 a.m. with the infection control nurse confirmed she would have expected the foam on the NuSteps to have been intact, the oxygen concentrator filters to have been clean, the towels not to have been stored on the floor in the mechanical room on the second floor, and the wooden surfaces to have had a finish on them, so they could be cleaned.</p> <p>Interview on 4/9/14 at 9:30 a.m. with the director of nursing confirmed she would have expected the foam on the NuStep to have been intact, the oxygen filters to have been clean, the towels not to have been stored on the floor, and the wooden surfaces to have a finish on them for cleaning.</p> <p>Review of the provider's reviewed 6/12/12 Infection Control Policy revealed: *The purpose was to "prevent infectious processes from spreading." **E. Patient/Resident-Care Equipment. Handle and clean used patient/resident-care equipment in a manner that prevents transfer of microorganisms." **F. Environmental Control. Ensure that routine care, cleaning, and disinfection of environmental surfaces, beds, handrails, bedside equipment, tables and other frequently touched surfaces, occurs."</p>	F 441	<p><i>by the dept director starting in May, 2014 and will continue until the QIC advises to discontinue.</i></p> <p><i>*The unsealed base under the recliner was sealed. mpj/kdd/hmf</i></p>	

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
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F 441	<p>Continued From page 10 Surveyor: 29162 2. Observation and interview on 4/9/14 at 2:00 p.m. in the beauty shop with the on-staff beautician revealed:</p> <p>a. There was an oxygen concentrator with a green adaptor plugged in by the north wall. *The beautician stated: -She used the oxygen concentrator for any resident with oxygen that came to the beauty shop for her services. -Each resident used their own oxygen tubing. -She connected each resident's oxygen tubing to the same adapter on the oxygen concentrator. -That adapter was not cleaned or changed between residents.</p> <p>b. There was an open plastic container with brush curlers in it on the counter. *There was a pair of scissors and a comb laying on the counter. *The on-staff beautician had an active cosmetology license. *The beautician stated she: -Did not disinfect the brush curlers between residents. -Disinfected them "every month or so with Brush Delight." She had been unable to locate any Brush Delight disinfectant during the interview. -Did not disinfect her comb between resident use, and stated she just knew their (residents) hair was clean. -Disinfected her comb every month or so with the Brush Delight. -Wiped her scissors off with a wipe between resident use. Had been unable to state the name of that wipe. -Found a container of Kwik Kill disinfecting wipes in the back of the storage cabinet.</p> <p>Interview on 4/9/14 at 2:40 p.m. with the DON</p>	F 441	<p><i>F441 * MDR/DDH/MF</i></p> <p><i>[Redacted]</i></p> <p><i>An in service was provided to the facility beautician 5/7/14. The Salon Self-inspection checklist will be completed daily by the beautician. The Activities coordinator will review the checklists weekly. The activities coordinator will provide a monthly report to the QI coordinator. The monitor will be continued quarterly until QIC advises to discontinue</i></p> <p><i>*The oxygen concentrator has been removed from the beauty shop. The combs, scissors and curlers were immediately sanitized. Combs, scissors and curlers are currently sanitized after each use.</i></p> <p><i>MDR/DDH/MF</i></p> <p><i>5/7/14</i></p>

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F 441	<p>Continued From page 11</p> <p>revealed the oxygen concentrator should have been cleaned between resident use. The brush curlers, scissors, and comb should have been disinfected between resident use.</p> <p>A policy for cleaning and disinfecting of the beauty shop items and for oxygen use in the beauty shop had been requested. The requested policy had not been received by 5:00 p.m. on 4/9/14 at the time of survey exit.</p> <p>From: <a href="http://dlr.sd.gov/bdcomm/cosmet/documents/ccsc_ope.pdf">http://dlr.sd.gov/bdcomm/cosmet/documents/ccsc_ope.pdf</a>, SOUTH DAKOTA COSMETOLOGY COMMISSION SDCL 36-15 HEALTH, SAFETY AND SANITARY RULES ARSD 20:42 FOR SALONS, BOOTHS, SCHOOLS, AND INDIVIDUALS: 5.Equipment: "a closed container for all licensees or separate containers for each licensee to be used for sanitation of all instruments which shall contain a bactericidal, virucidal, and fungicidal disinfecting agent that is registered with EPA."</p> <p>From:<a href="http://dlr.sd.gov/bdcomm/cosmet/document_s/ccsalonself13.pdf">http://dlr.sd.gov/bdcomm/cosmet/document_s/ccsalonself13.pdf</a> South Dakota Cosmetology Commission SALON SELF-INSPECTION CHECKLIST 2007EQUIPMENT: "25 - 27. For hair services, are all scissors, razors, brushes, combs, rollers, picks, clips, rods, pins, etc. to be used on a client clean and disinfected (no hair or debris)? 31- 32. Is all electrical equipment (clippers, files, curling irons, facial machines) clean? All foreign debris should be wiped or washed off (AND clippers sprayed with disinfectant before each client)."</p>	F 441			

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K062  
waived until  
9/9/14

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2014
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AVERA MARYHOUSE LONG TERM CARE

STREET ADDRESS, CITY, STATE, ZIP CODE  
717 EAST DAKOTA  
PIERRE, SD 57501

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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/08/14. Avera Maryhouse Long Term Care (south resident wing - 1977 addition) 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 4/15/14 upon correction of the deficiencies identified below.	K 000	Addendums noted with an asterisk per 5/14 telephone to facility plant operations director. CH/SDDOH/MF	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one of two ground	K 038	Sidewalk installed 4/25/14 to connect paved areas.  *The plant operations director will monitor the correction of this item and will report its completion to the QA committee. CH/SDDOH/MF	4/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mark Schmidt* TITLE: Executive Director (X6) DATE: 5/7/14

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 180 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  <b>AVERA MARYHOUSE LONG TERM CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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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) COMPLETION DATE
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K 038	<p>Continued From page 1</p> <p>floor exits. The center stair exit discharge on the west side of the building had a sidewalk that ended approximately 50 feet from the nearest street. Findings include:</p> <p>1. Observation at 10:30 a.m. on 4/08/14 revealed the center stair exit discharge on the west side of the building had a sidewalk that ended approximately 50 feet from the nearest street. Interview with the plant operations director at the time of the observation confirmed that finding. He stated that condition had existed for over 35 years.</p> <p>B. Based on observation and interview, the provider failed to ensure two of three exits on the third floor (SW stair door exit and center stair exit) were readily accessible at all times. There was not any signage indicating how to open the locked delayed egress doors in the event of an emergency. Findings include:</p> <p>1. Observation beginning at 11:00 a.m. on 4/08/14 revealed the third floor exit doors (SW stair and center stair) were equipped with devices that would magnetically lock the doors when a resident with a wander management device came in close proximity to the exit. Testing of the door magnets revealed the locks were delayed-egress type. There was not any signage indicating how to open the locked delayed egress doors in the event of an emergency. Interview with the plant operations director at the time of the observations confirmed those findings. He revealed the third floor had been a secured unit in the past. The magnetically locked doors had been used for that occupancy.</p> <p>Ref: 2000 NFPA 101 Section 19.2, 7.2.1.6.2</p>	K 038	<p><i>Signage installed on all 3 doors to identify delayed egress operations.</i></p>	<p><i>4-23-14</i></p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>		
(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 044 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain 90 minute horizontal exit doors in operating condition. The horizontal doors separating building 01 and building 02 on the third floor when closed provided a gap clearance between the door and the floor greater than 3/4 inch. Findings include:</p> <p>1. Observation and testing at 1:30 p.m. on 4/08/14 revealed the cross-corridor horizontal exit doors separating building 01 and building 02 on the third floor when closed failed to maintain the 90 minute fire resistive rating of the assembly. The doors when closed provided 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.</p> <p>Interview with the director of plant operations at the time of the observation 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.</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 044		F =	

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NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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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) COMPLETION DATE
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K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>A. Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required inspections performed (five year internal obstructive inspection during the previous 72 months, May 2008 through April 2014; annual backflow preventer inspection during the past twelve months). Record review of the previous 72 months annual fire sprinkler system inspections revealed five year internal obstructive inspection and annual backflow preventer inspection documentation was not available. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection reports for the past 60 months (May 2009 through April 2014) revealed no documentation was available showing the required five-year internal obstructive inspection had been performed. There was also no documentation the sprinkler system annual backflow preventer inspection/testing had been performed. Interview with the plant operations director at the time of the record review confirmed those findings.</p> <p>B. Based on observation and interview, the provider failed to ensure the automatic sprinkler system was in reliable operating condition in</p>	K 062	<p><i>Building Sprinkler will be on site in August 2014 to review and complete inspections and testing.</i></p>	<p><i>5/29/14</i></p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
(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 062	<p>Continued From page 4</p> <p>resident rooms 112 and 113. The privacy curtains did not have any conforming mesh openings, and there were no sprinklers located on the side of the curtain away from the residents' bed locations. Findings include:</p> <p>1. Observation at 10:15 a.m. on 4/08/14 revealed resident rooms 112 and 113 had privacy curtains around the beds without any conforming mesh at the top. There were no sprinklers located on the side of the curtain away from the residents' beds. The sprinklers that were in the room would be obstructed by the closed privacy curtains. Interview with the plant operations director at the time of the observation confirmed those findings.</p> <p>The deficiency affected components of the building's required maintenance and testing regarding the automatic fire sprinkler system.</p> <p>Ref: 2000 NFPA 101 Section 19.3.5, NFPA 25</p>	K 062	<p><i>Maintenance Supervisor reviewed additional areas to determine any other changes necessary and found no other items so new curtains were added in rooms 112 &amp; 113.</i></p> <p><i>*The Plant Operations Director will monitor correction of this item and report its completion to the QA committee. CH/SDDOH/ME</i></p>	<i>4-22-14</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - BUILDING 02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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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) COMPLETION DATE
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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/08/14. Avera Maryhouse Long Term Care (east patient wing - 1992 addition) 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 4/15/14 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 intent to correct the deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 5/14/14 telephone to facility plant operations Director. CHSDOH/ME	
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: 18087	K 033		'F'

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maureen S. Stewart</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>5/7/14</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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If continuation sheet Page 4 of 4  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> - <b>BUILDING 02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>		
(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 033	Continued From page 1 Based on observation and review of previous survey records, the provider failed to maintain a protected path of egress. The east stair enclosure discharged past unprotected window openings. Findings include:  1. Observation at 10:45 a.m. on 4/08/14 revealed the exterior sidewalk and steps from the east exit stair enclosure discharged past unprotected window openings. Review of previous survey records at the time of the observation revealed that condition had previously existed.  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 033		
K 044 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain 90 minute horizontal exit doors in operating condition. The horizontal doors separating building 02 and building 01 on the third floor when closed provided a gap clearance between the door and the floor greater than 3/4 inch. Findings include:  1. Observation and testing at 1:30 p.m. on 4/08/14 revealed the cross-corridor horizontal exit	K 044		"F"

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>		
(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 044	Continued From page 2 doors separating building 02 and building 01 on the third floor when closed failed to maintain the 90 minute fire resistive rating of the assembly. The doors when closed provided 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 director of plant operations at the time of the observation 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.	K 044		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required inspections performed (five year internal obstructive inspection during the previous 72 months, May 2008 through April	K 062		F

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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K 062	<p>Continued From page 3</p> <p>2014; annual backflow preventer inspection during the previous twelve months, May 2013 through April 2014). Record review of the previous 72 months annual fire sprinkler system inspections revealed five year internal obstructive inspection and annual backflow preventer inspection documentation was not available. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection reports for the past 60 months (May 2009 through April 2014) revealed no documentation was available showing the required five year internal obstructive inspection had been performed. There was also no documentation the sprinkler system annual backflow preventer inspection/testing had been performed. Interview with the plant operations director at the time of the record review confirmed those findings.</p> <p>The deficiency affected components of the building's required maintenance and testing regarding the automatic fire sprinkler system.</p> <p>Ref: 2000 NFPA 101 Section 19.3.5, NFPA 25</p>	K 062	<p><i>Building Sprinkle Co. will be on-site in August to do annual inspections and tests.</i></p> <p><i>*The Plant Operations Director will monitor the correction of this item and will report its completion to the QA committee.</i></p> <p><i>CH/SDOH/MF</i></p>	5/26/14
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - BUILDING 03</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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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) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/08/14. Avera Maryhouse Long Term Care (building 03 common use area - original 1954 construction) was found not 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 and the Fire Safety Evaluation System (FSES) dated 4/15/14 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K038 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 5/14/14 telephone to facility plant operations Director. CH/SDDOH/ME</p>	
K 020 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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 one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and previous survey review, the provider failed to maintain the one</p>	K 020		"F"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark C Schmsat</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>5/2/14</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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - BUILDING 03</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>		
(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 020	Continued From page 1 hour fire resistive rating for stair three of three enclosures (north and east of the craft room and the southeast stairs). Findings include:  1. Observation during the survey on 4/08/14 revealed three stair enclosures with doors without a label identifying their fire resistive rating. Those doors were 1 3/4 inch hollow metal doors. The doors were located at the following locations: *To the stair enclosures north of the craft room on the first and second floors. *To the stair enclosures east of the craft room on the first and second floors. *To the southeast stair enclosures on first and second floors.  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 020			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		<b>F</b>	

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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K 029	Continued From page 2  This STANDARD is not met as evidenced by: Surveyor. 18087 Based on observation, document review, and interview, the provider failed to maintain proper separation of hazardous areas. The Kone elevator hydraulic room in the lower level was a hazardous room without a closer or fire-rated door. Findings include:  1. Observation at 1:45 p.m. on 4/08/14 revealed the Kone elevator hydraulic room had a solid bonded wood core (SBWC) corridor door without a label indicating its fire-resistive rating (an SBWC door has an equivalent to a 20 minute fire-rated door). The corridor door was also not equipped with a closer. Review of the Chevron hydraulic fluid specification documentation revealed the hydraulic fluid was combustible at 374 degrees Fahrenheit (see attachment). The room was considered to be a severe hazardous room requiring a one-hour fire-rated enclosure with a minimum 45 minute fire-rated door with a closer. Interview with the plant operations director at the time of the observations confirmed those findings.  The deficiency affected one of several hazardous areas in the building required to be provided with fire-rated self-closing doors to the corridor.	K 029	<i>Door was ordered on 4-10-14 and was received 5/5/14 will be installed by 5/29/14</i>  <i>*The Plant Operations Director will monitor the correction of this item and will report its completion to the QA committee.</i> <i>CHKSDDH/MF</i>	
K 062 SS=D	Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.1(3) NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - BUILDING 03</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>		
(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 062	Continued From page 3 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required inspections performed (five year internal obstructive inspection during the previous 72 months, May 2008 through April 2014; annual backflow preventer inspection during the past twelve months). Record review of the previous 72 months annual fire sprinkler system inspections revealed five year internal obstructive inspection and annual backflow preventer inspection documentation was not available. Findings include:  1. Review of the provider's automatic sprinkler system inspection reports for the past 60 months (May 2009 through April 2014) revealed no documentation was available showing the required five year internal obstructive inspection had been performed. There was also no documentation the sprinkler system annual backflow preventer inspection/testing had been performed. Interview with the plant operations director at the time of the record review confirmed those findings.  The deficiency affected components of the building's required maintenance and testing regarding the automatic fire sprinkler system.  Ref: 2000 NFPA 101 Section 19.3.5, NFPA 25	K 062	<i>Building Sprinkler Co. will be here in August to complete annual inspections. we will do internal inspections at that time. *The Plant operations Director will monitor the correction of this item and will report its completion to the QA committee. CH/SD/DMF</i>	<i>5/29/14</i>	