

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

ORIGINAL

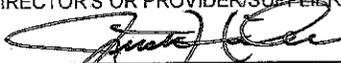
PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER AVERA PRINCE OF PEACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103
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F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted from 9/16/14 through 9/18/14. Avera Prince of Peace was found not in compliance with the following requirements: F226, F323, F431, and F441.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on interview and policy review, the provider failed to implement procedures to investigate and report to the South Dakota Department of Health (SD DOH) one of one sampled resident's (9) reporting of missing items. Findings include: 1. Interview on 9/16/14 at 2:00 p.m. and on 9/17/14 at 4:00 p.m. with resident 9 revealed: *Approximately two to three months ago she had lost a glass case that contained an expensive pair of sunglasses. *Inside the case she had also put several identification cards including her Medicare identification card, insurance cards, and Social Security Card as she had carried the glass case to a recent appointment.	F 226	<p>Addendums noted with an asterisk per telephone to facility administrator. CS/SDDH/MF</p> <p>F226 Resident 9's CS/SDDH/MF</p> <p>A report regarding missing items was sent to the DOH on 9/22/14. The abuse and neglect and reporting policy was updated on 10/10/14 to reflect social services as the department responsible to track and report missing items. Social Services will also be responsible for follow up with the family and resident. Reporting missing items to the DOH will be per the discretion of the DON, Coordinator, and social services as written in the policy. The updated policy will be reviewed at the mandatory Social service and Coordinator meeting on 10/13/14 and the mandatory all staff and nursing meetings to be held on 10/13/14, 10/14/14, 10/15/14, and 10/16/14. The DON will monitor the missing item tracking log on a weekly basis for 3 months to monitor for compliance with the updated policy and procedure. The results of the tracking will be reported at the Every other week QAPI meeting by the DON and to the every other month PI meeting by the DON. Further tracking audits will be per the discretion of The PI committee.</p>	11/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-14-14
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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.

DISCLOSED

OCT 16 2014

continuation sheet Page 1 of 13

SD DOH L&C

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F 226	<p>Continued From page 1</p> <p>*The case had disappeared with all the contents. *She had reported that to staff. *She had never heard any more about it, and the glass case and contents had never been found.</p> <p>Interview on 9/17/14 at 3:00 p.m. with social worker G revealed she had not been involved in the investigation of resident 9's personal identification cards or sunglasses.</p> <p>Interview on 9/17/14 at 5:00 p.m. with the director of nursing (DON) regarding resident 9's missing glass case revealed she: *Was aware the resident had reported that her glass case with the sunglasses had disappeared from her room. *Was also aware the glass case contained resident identification information. *Had not investigated the missing items. *Had not reported that to the SD DOH. *Confirmed that having lost all of her personal identification information was pretty significant and should have been investigated.</p> <p>Review of the provider's 1/7/13 Social Services Abuse Prevention and Prohibition policy revealed: **All staff are expected to report suspected abuse, neglect, and misappropriation of property immediately upon suspicion; failure to report will result in corrective action in addition to notification to Board of Nursing of negligence if nursing staff had knowledge but did not report concern. *Property that is missing will be tracked on the missing property log in the abuse and reporting book.</p> <p>-a. Documentation will include: Resident name, staff assigned to wing, date and time. -b. DON/coordinator will follow up with the resident/staff on the wing.</p>	F 226			

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F 226	Continued From page 2 -c. Report will be sent at discretion of DON/coordinator. *Investigation and follow up needs to be completed within 5 days with follow up report to SD.DOH and DSS [Department of Social Services]."	F 226		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure: *Chemicals were stored securely away from residents access during three of five random observations of four housekeeping carts. *Four of four randomly observed EZ Way Stands (mechanical lift used for transferring residents) had safety tabs per manufacturer 's guidelines. Findings include: 1. Random observations on 9/16/14 through 9/17/14 of two housekeeping carts revealed: *They had been observed in various locations in the facility. *No housekeeping staff had been in attendance or monitoring their carts during any of the observations.	F 323	The housekeeping staff completed an inservice on 9/25/14 &10/10,13,14 regarding securing chemicals safely on all housekeeping carts when the housekeeping carts are not in the line of site of housekeeper. Housekeeping cart keys shall remain with the employee at all times. The Support Services Manager shall conduct weekly housekeeping cart audits for 8 weeks to ensure chemicals are secured. The housekeeping cart/chemicals practice will be reviewed at the October 13,14,15,16 All Staff Meeting. The Support Services Manager will report audit results at the Performance Improvement meeting held every other month. The PI Committee will direct further audits. <i>*The Safety committee will continue monthly audits thereafter. ASD/DMF</i>	11/7/14

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F 323	<p>Continued From page 3</p> <p>*The housekeeping carts had been unlocked and contained the following chemicals: -One spray bottle of Neutral cleaner. -One spray bottle of non-acid bathroom cleaner. -One spray bottle of 3M HB Quaternary disinfectant cleaner. -One spray bottle of glass cleaner.</p> <p>*Several residents were wandering up and down the hallways in the area of the housekeeping carts.</p> <p>Observation on 9/16/14 at 1:50 p.m. of the housekeeping cart located on Birch hallway revealed: *No housekeeping staff had been in attendance or monitoring the cart. *The cart had been locked, but the keys to open the cart had been lying on the lid to the left. *Housekeeper B returned to the cart shortly after the observation. She had: -Retrieved the keys from the lid and opened the housekeeping cart to replace an unidentified chemical. -Closed the cart, locked it with those keys, and laid the keys back on top of the lid. -Entered an unidentified room. -She had been out of site of the cart.</p> <p>Interview on 9/16/14 at the time of the observation with housekeeper B revealed the housekeeping carts should have been locked when not in attendance. The keys should have been kept with the staff.</p> <p>Interview on 9/17/14 at 7:40 a.m. with housekeeper A and the housekeeping supervisor revealed: *The housekeeping carts should have been locked when not within site of the housekeepers.</p>	F 323		

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F 323	<p>Continued From page 4</p> <p>*The keys to open the housekeeping carts should not have been left on the lid of the cart. *The housekeeping cart keys should have been kept with the housekeeper.</p> <p>Review of the provider's May 2014 General Safety Guidelines for Housekeeping revealed "If cleaning cart is not within the line of site, cart should be secured."</p> <p>2. Random observations from 9/16/14 through 9/17/14 of four EZ Way Stand mechanical lifts revealed they had no safety tabs attached to the harness attachment area. Those tabs were to ensure the residents would not have fallen from the mechanical lift.</p> <p>Interview on 9/17/14 at 8:20 a.m. with the administrator, maintenance supervisor, and DON revealed: *The representative for the EZ Stand mechanical lifts had been there in May 2014 to check the lifts. *Some of the safety tabs had been missing at that time. *The safety tabs had been ordered and replaced. *They had not been aware the mechanical lifts currently had safety tabs missing.</p> <p>Review of the provider's EZ Way Smart Stand Operator's Instructions revealed: **"It is important that certain basic checks be periodically made by maintenance staff to ensure on-going safety throughout the life of the device." **"The manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than one month." **"Any detected deficiency must be rectified before the stand is put back into service."</p>	F 323	<p>Safety Tabs were replaced September 17, 2014. The care assistant staff completed inservice training on October 13,14,15,16 regarding the importance of the Safety tabs on the harness for the EZ stand. Safety tabs should remain on the harness at all times and report any breakage to the Maintenance department. The Nurse Coordinators shall conduct weekly safety tab audits for 8 weeks to ensure proper working order. The Avera Prince of Peace Safety Committee will conduct random monthly audits for 3 months to ensure safety tabs are in place and in satisfactory condition. The Nurse Coordinator will report audit results at the Performance Improvement meeting held every other month. The PI committee shall direct further audits.</p>	11/7 /14

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F 323 F 431 SS=C	<p>Continued From page 5</p> <p>*"Safety tabs need to be checked to make sure they are in place."</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 323 F 431		

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F 431	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to prevent unauthorized access to medication keys for three of four wings of the building. Findings include:</p> <p>1. Random observations on 9/16/14 and on 9/17/14 of staff at the nurses' station revealed: *Staff had opened a drawer at the nurses' station and removed a key upon the start of their shift at 6:30 a.m. *Those keys had been identified by certified nursing assistants (CNA) F as medication keys, and were used by CNAs to administer medications to the residents throughout their shift each day. *This surveyor had been alone at the nurses' station for fifteen minutes on 9/17/14 from 4:45 p.m. to 5:00 p.m. and had full access to the above keys in that drawer.</p> <p>Interview on 9/17/14 at 7:45 a.m. with CNA F regarding the medication keys revealed: *She would go to the unlocked drawer at the nurses' station at the start of her shift and take a key from the drawer. *She would keep the key in her pocket and return it to the unlocked drawer at the end of her shift.</p> <p>Interview on 9/17/14 at 8:30 a.m. with registered nurse (RN) E regarding the above mentioned medication keys confirmed the above interview with CNA F.</p> <p>Interview on 9/17/14 at 5:00 p.m. with the director of nursing revealed she:</p>	F 431	<p>F431</p> <p>A policy regarding release and acceptance of medication cabinet keys and a sign out sheet for each key was created on 9/22/14. A lock was added to the drawer on 9/22/14.</p> <p>Staff will be educated on the policy and procedure at the mandatory all staff and nursing meetings on 10/13/14, 10/14/14, 10/15/14, and 10/16/14.</p> <p>The DON will audit the sign out sheets every other day for compliance for 3 months. The DON will report the audit findings to the QAPI team that meets every other week and also to the PI committee that meets every other month. Further audits will be at the discretion of the PI committee.</p>	11/7/14

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F 431	Continued From page 7 *Stated each wings charge nurse was supposed to have handed out a key to the CNAs each shift. *Agreed there had been no way to know: -Which CNA had which key. -How long they had the key. -Who had the key last if one was found to have been missing. *Agreed anyone would have been able to walk into the nurses' station, pull open the drawer, and have full access to the medication keys. *Stated she needed to lock the keys to limit access by unauthorized personnel. *Agreed there had been no system in place to keep unauthorized personnel from taking a key or accountability for whom had which key.	F 431		
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 to help prevent the development and transmission of disease and infection. (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.	F 441		

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F 441	<p>Continued From page 8</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: 32355 Based on observation, interview, and policy review, the provider failed to ensure: *One of two housekeepers (B) was educated on proper chemical use for the cleaning of all the resident's bathrooms. *Two of two observed registered nurses (RN) (C and D) maintained sanitary conditions during suctioning and tracheostomy (tube to help with breathing) care for one of one sampled resident (4). *Four of four randomly observed EZ stands (mechanical lift used for transferring residents) bases were clean. Findings include:</p>	F 441		

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F 441	<p>Continued From page 9</p> <p>1. Interview on 9/16/14 at 1:45 p.m. with housekeeper B revealed: *She would have cleaned the resident's bathrooms with 3M HB Quaternary disinfectant cleaner. *She would have sprayed the surfaces of the toilet and sink with the 3M HB Quaternary disinfectant cleaner. *She would not have allowed the cleaner to remain on the surfaces for any length of time. *She would have wiped the surfaces dry after cleaning them.</p> <p>Review of the January 2003 3M HB Quaternary disinfectant cleaner instructions pamphlet revealed "All surfaces remain wet for ten minutes."</p> <p>Interview on 9/17/14 at 7:35 a.m. with the housekeeping supervisor confirmed the 3M HB Quaternary disinfectant cleaner should have remained on all surfaces for no less than ten minutes.</p> <p>2. Observation on 9/16/14 at 11:45 a.m. of RN C during suctioning of a tracheostomy for resident 4 revealed: *He had entered the resident's room and gathered the necessary supplies to suction her tracheostomy. *Without washing his hands he had put on a pair of sterile gloves. *With those gloved hands he had: -Removed her tracheostomy cover and placed it directly on her bedside table without a barrier. -Turned on the suction meter attached to the wall. -Retrieved a package containing the suction tubing from a bedside dresser. -Opened the package, retrieved the suction</p>	F 441	<p>The housekeeping staff completed education training 10/10, 10/13, 10/14 On proper procedures and use of facility chemicals. The housekeeping supervisor shall conduct weekly housekeeping audits for 8 weeks to ensure proper chemical usage and recommended drying time for specific chemicals. The proper chemical usage procedure will be reviewed at the October 13,14,15,16, 2014 All Staff Meetings. The housekeeping supervisor will report audit results at the Performance Improvement meeting held every other month. The PI Committee will direct further audits.</p>	11/7/14

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F 441	<p>Continued From page 10 tubing, and attached it to additional tubing attached to the suction canister.</p> <ul style="list-style-type: none"> -Suctioned the resident's tracheostomy. *After he had finished suctioning the resident's tracheostomy he had: <ul style="list-style-type: none"> -Replaced the cap on her tracheostomy. -Placed the soiled suction tubing in the garbage. -Removed his gloves. *He put on another pair of gloves without washing or sanitizing his hands. *With those gloved hands he had: <ul style="list-style-type: none"> -Retrieved a soiled gown lying directly on the resident's floor in her room. -Retrieved a garbage sack from the garbage basket. -Placed the soiled gown inside of the garbage bag. -Opened the resident's door and walked down the hallway to the soiled linen room. -Opened the door to the soiled linen room and disposed of the soiled gown. *He had not been observed washing or sanitizing his hands during any of the processes mentioned above. <p>Observation on 9/17/14 at 7:55 a.m. of RN D during suctioning and cleansing a tracheostomy for resident 4 revealed:</p> <ul style="list-style-type: none"> *She had gathered the necessary supplies to suction the resident. *She had put on a pair of sterile gloves and suctioned resident 4. *After she had completed the suctioning process she had: <ul style="list-style-type: none"> -Removed her sterile gloves and gathered the necessary supplies from a bedside table to cleanse the tracheostomy site. -Put on another pair of gloves and cleansed the resident's tracheostomy site. 	F 441	<p><i>x for Resident 4 CS/SDDO/HMF</i></p> <p>F441</p> <p>The policies on tracheostomy care and suctioning as well as clean and sterile technique and glove use will be reviewed at the Mandatory Nursing meetings on 10/13/14, 10/14/14, 10/15/14, and 10/16/14. The RN coordinator staff will audit 3 events per week of dressing changes and suctioning and glove use for proper technique for 3 months. The results of the audits will be reported by the RN coordinators to the QAPI team that meets every other week and also to the PI committee that meets every other month. Further audits will be per the discretion of the PI committee.</p> <p>The policy and procedure for cleaning multi use equipment was updated on 10/10/14 to include the need to clean the lifts at the end of each shift and when visibly soiled. Cleaning lists were also updated to reflect this change. Staff received education on the updated policy at the mandatory all staff and nursing meetings on 10/13/14, 10/14/14, 10/15/16, and 10/16/14. The RN coordinators will audit the cleaning lists and equipment twice a week for compliance for 3 months. The results of the audits will be reported to the QAPI team that meets every other Week and to the PI committee that meets every other month. Further audits will be per the discretion of the PI committee.</p>	11/7 /14	

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

PRINTED: 10/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2014
NAME OF PROVIDER OR SUPPLIER AVERA PRINCE OF PEACE		STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103		
(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 441	<p>Continued From page 11</p> <p>*After she had completed the cleansing process she disposed of the supplies and removed her gloves and sanitized her hands.</p> <p>*She had not been observed cleansing or sanitizing her hands between the suctioning process and cleansing of the tracheostomy.</p> <p>Interview on 9/17/14 at the time of the observation with RN D confirmed: *She should have washed or sanitized her hands after she had completed the suctioning process for resident 4. *The above procedure had created the potential for infection.</p> <p>Interview on 9/18/14 at 7:50 a.m. with the director of nurses (DON) confirmed the above observations had not been a sanitary process. The above procedure had created the potential for cross-contamination and infection.</p> <p>Review of the provider's February 2014 Hand Hygiene policy revealed: *"Hand hygiene is the single most important procedure for the control of infection." *"It is a critical component of patient and employee safety." *Hand hygiene should be performed after glove removal.</p> <p>Review of the provider's May 2012 Open-suction Technique for Tracheostomy Tubes policy revealed the sterile field should have been set-up prior to putting on the sterile gloves.</p> <p>3. Random observation throughout the facility on 9/16/14 through 9/17/14 of four EZ Way stand mechanical lifts revealed the bases had been soiled with tan, brown, and black colored debri.</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2014
NAME OF PROVIDER OR SUPPLIER AVERA PRINCE OF PEACE			STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103		
(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 441	Continued From page 12 Interview on 9/17/14 at 10:45 a.m. with certified nursing assistant H revealed the night shift staff were to have cleaned the EZ stand mechanical lifts. Interview on 9/18/14 at 8:00 a.m. with the DON confirmed the night shift staff were to have cleaned the EZ stand mechanical lifts. She had not been able to provide a schedule for when those mechanical lifts had last been cleaned. Review of the provider's 7/23/14 Equipment Cleaning guideline revealed: **Stand/hoyer lifts were to have been cleaned daily and when visibly soiled." **Night staff will complete per schedule."	F 441			

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

ORIGINAL

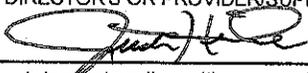
PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2014
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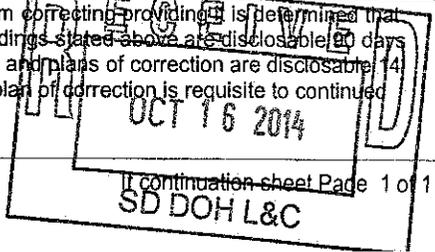
NAME OF PROVIDER OR SUPPLIER AVERA PRINCE OF PEACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/16/14. Avera Prince of Peace was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-14-14
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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 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

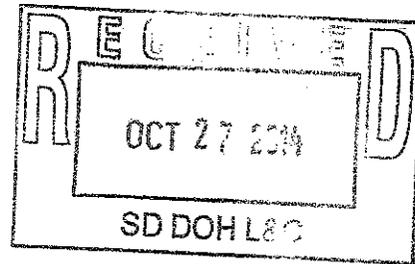


South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2014
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NAME OF PROVIDER OR SUPPLIER AVERA PRINCE OF PEACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PRINCE OF PEACE PLACE SIOUX FALLS, SD. 57103
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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
S 000	<p>Initial Comments</p> <p>Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/16/14 through 9/18/14. Avera Prince of Peace was found in compliance.</p>	S 000		11/7/14



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

TITLE

Administrative

(X6) DATE

10-14-14