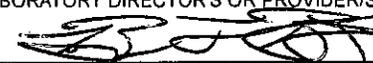


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/1/15 through 9/2/15. Avera Oahe Manor was found not in compliance with the following requirements: F176, F280, F323, F441, and F520.	F 000	* Addendums noted with an asterisk per 10/8/15 per telephone from facility DON and Administrator. JK/SDPOH/EL	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to ensure one of one resident (12) who self-administered a medication during two of two observations had been assessed for her capability to self-administer medications. Findings include: 1. Observation and interview on 9/1/15 at 9:50 a.m. of registered nurse (RN) C during a medication administration of a nebulizer (machine that turns liquid medication into a mist for inhaling into the lungs) treatment for resident 12 revealed the nurse had: *Placed the medication into the nebulizer chamber. *Placed the inhalation device into resident 12's hand.	F 176	F176 Assessment of resident 12 was completed. Physician order for self-administration of nebulizer was obtained and care plan was reviewed and revised. After this was completed, resident 12 may self-administer her nebulizer when dispensed by nurse or medication aide. Self-administration of nebulizer will be placed on her Electronic Medication Administration Record (eMAR) for assessment weekly. Self-Administration of Medication Policy was updated to include nebulizers. Four (4) other residents have been assessed for self-administration of nebulizer including an order, care planning, and weekly eMAR checks. If a resident is not competent to self-administer medications, the nurse or medication aide will remain with the resident during administration of the nebulizer.	10/22/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Interim Administrator</i>	(X8) DATE <i>9-24-15</i>
---	---------------------------------------	-----------------------------

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.

SEP 25 2015
SD DON LSC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442
---	---

(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 176	<p>Continued From page 1</p> <ul style="list-style-type: none"> *Started the nebulizer machine. *Left the resident's room and returned approximately fifteen minutes later. *Shut off the nebulizer machine. *Rinsed the mask and chamber with water in the sink. *Placed the next nebulizer medication that was ordered into the nebulizer chamber. *Placed the nebulizer device into the resident's hand. *Started the machine at 10:10 a.m. *Left the room and did not return. *At 10:27 a.m. the machine was off in the resident's room, and she was in the bathroom. *RN C thought a medication aide had been in the room and shut the machine off. *RN C stated: <ul style="list-style-type: none"> -She would not have stayed with any resident during the nebulizer treatments. -Nurses did not stay to watch nebulizer treatments. -She was unsure if they needed a physician's order to leave the resident alone to administer the nebulizer treatment. <p>Review of resident 12's medical records revealed:</p> <ul style="list-style-type: none"> *There had not been a physician's order for medication self-administration. *Her care plan had indicated she had impaired decision making and poor safety awareness. *The care plan had not indicated the resident was capable of self-administering medications. <p>Interview on 9/1/15 at 3:45 p.m. with the Minimum Data Set (MDS) assessment nurse revealed:</p> <ul style="list-style-type: none"> *She had not considered leaving a resident during a nebulizer treatment for self-administration of that med. *She confirmed if the nurse was not present for 	F 176	<p>F176 A Quality Assurance Performance Improvement (QAPI) study was conducted by the nursing coordinator or designee monthly to ensure nebulizers have orders, assessments and plans addressed or nurse remains with resident during administration. The Director of Nursing or designee will monitor completion of the QAPI study quarterly and will report to the QAPI Committee meeting until committee advises to discontinue.</p> <p>→ All residents with self-administered JK/SDDOH/EL</p> <p>← quarterly JK/SDDOH/EL</p>	
-------	--	-------	--	--

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442
---	---

(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 176	<p>Continued From page 2</p> <p>the duration of the administration there was a potential for the resident to take off the nebulizer mask and not get the full dose of the medication.</p> <p>*She agreed nurses would have set-up the nebulizers, left the room, and came back after it was finished.</p> <p>-They would not have stayed with the resident for the duration of the nebulizer treatment.</p> <p>*She confirmed there was not a self-administration assessment completed for resident 12 to self-administer her nebulizer treatment.</p> <p>*She agreed there were not physician's orders for her to self-administer medications after set-up by the nurses.</p> <p>*Typically if a resident wanted to self-administer medications there would have been an assessment and physician's orders to do that.</p> <p>Interview on 9/2/15 at 2:35 p.m. with the director of nursing revealed:</p> <p>*Nurses generally did not stay in the room with a resident for the duration of the nebulizer treatment.</p> <p>*They would have started the nebulizer treatment and returned when it was finished.</p> <p>*She agreed the residents would have been administering the nebulizer after set-up by the nurse.</p> <p>*They had not recognized nebulizers as self-administration of medication in the past.</p> <p>*They had not done self-administration of medication assessments for nebulizers.</p> <p>*They should have had physician's orders for the resident to self-administer after set-up if they were assessed as safe to do so on their own.</p> <p>Review of the provider's January 1999 Pharmaceutical Service policy revealed "self</p>	F 176		
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015	
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 176	<p>Continued From page 3</p> <p>administration of drugs by the resident will only be done if the Medical Provider so orders."</p> <p>Review of the provider's undated Self-Administration of Medication policy revealed: *"All medication will be administered by the nursing staff, unless specifically ordered for self-administration by the provider." *"The patient is deemed competent to self-administer medications by the provider and through assessment by the RN."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 565, revealed: "In all settings, nurses are responsible for evaluating the effects of medications on the patient's ongoing health status, teaching them about their medications, and side effects, ensuring adherence to the medication regimen, and evaluating the patient's and family caregiver's ability to self-administer medications."</p>	F 176		
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,</p>	F 280	<p>F280 Resident 1, 7, and 9 had care plans reviewed and revised to reflect changes in care related to falls and to reduce future falls. Interventions to resident 1 care plan included decreased medication and seeking chair pressure pad alarm. Resident 9 has not fallen since 06/08/2015 with intervention reviewed at Nurses Staff meeting. Resident 9 assessed and care plan revised. Interventions added include medication change and use of a short backed dining room chair.</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442	
(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 280	<p>Continued From page 4</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans had been updated to reflect current residents' needs for three of nine sampled residents (1, 7, and 9). Findings include:</p> <p>1. Review of resident 7's care plan had not been updated to reflect changes in care related to falls and to prevent future falls. Refer to F323, finding 4A.</p> <p>Surveyor: 35237 2. Review of resident 1 and 9's care plans revealed they had not been updated to reflect changes in care related to falls and to prevent future falls. Refer to F323, findings 1 and 2.</p> <p>3. Interview on 9/2/15 at 3:50 p.m. with the director of nursing (DON), interim administrator, and new administrator regarding care plan updates in regards to falls revealed: *Falls would have been discussed sometimes during Minimum Data Set (MDS) or care plan meetings and at the monthly nursing meetings. -They would have identified the number of falls but not what had happened to cause those falls.</p>	F 280	<p>F280 Resident 7 care plan reviewed and revised with the addition of a toileting plan intervention. Additional residents and their care plans were reviewed and revised with interventions.</p> <p>Education was provided to nursing staff regarding reviewing and revising the care plan and interventions as appropriate at the time of a fall. This education included a list of interventions and the revised fall policy. Care Plan Team will continue to review falls to ensure individualized assessment and approaches are evaluated quarterly. QAPI study will be completed monthly x 3 by [redacted] to ensure care plans are updated with interventions after every fall. Monitored monthly by the Director of Nursing or designee and reported quarterly at QAPI meeting until committee advises to discontinue.</p> <p>Change nurses after every fall JK/SDDOHT/EL</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 280	<p>Continued From page 5</p> <p>*Fall interventions were decided at the time of the fall.</p> <p>-No one reviewed those interventions to make sure they were appropriate.</p> <p>*Care plan updates/revisions should have been done by the nurse after the fall.</p> <p>-There should have been interventions on the care plan for each fall, not just the date of the fall listed.</p> <p>*They agreed:</p> <p>-Fall interventions should have been individualized for each resident.</p> <p>-There were a lot of different interventions that could have been tried to prevent falls.</p> <p>-Encouraging or reminding a resident with cognitive (memory, thinking, reasoning) impairment to use the call light was not an appropriate intervention.</p> <p>-There was a problem with the system related to falls in the facility.</p> <p>Review of the provider's April 2012 Care Planning policy revealed:</p> <p>*The purpose was "To develop individualized care plans for each resident according to their needs, behaviors and diversions which work for them."</p> <p>*1. "The care planning assessment team consists of nurses, nurse aides, pastoral care, restorative aides, dietary, activities and social service personnel.</p> <p>*2. The care planning team meets weekly to evaluate residents and their care. A problem solving approach is used by the team to deal with difficult behaviors, physical limitations and chronic disease.</p> <p>*3. Residents are evaluated quarterly or more frequently if hospitalized or changes occur."</p>	F 280		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323 SS=G	<p>Continued From page 6 HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237</p> <p>Surveyor: 32573 (Surveyor: 35237)</p> <p>A. Based on observation, interview, record review, and policy review, the provider failed to implement appropriate interventions to prevent future falls for three of nine sampled residents (1, 7, and 9) who had multiple falls. Findings include:</p> <p>1. Review of resident 9's medical record revealed: *She had been admitted on 2/11/14. *She was alert with memory problems and forgetfulness. *She had a Brief Interview for Memory Scale (BIMS) (memory test) score of nine that indicated moderate memory issues. *She required extensive assistance of one staff member for moving in bed, walking, dressing, personal hygiene, and using the toilet. *She required supervision and set-up assistance with eating. *Her diagnoses included high blood pressure, depressive disorder (sadness), subacute dyskinesia due to drugs (neurological disorder</p>	F 323	<p>F323 Residents 1, 7, and 9 were assessed and interventions for care plans were reviewed and revised to include interventions currently in use to prevent falls including a toileting plan.</p> <p>Interventions to resident 1 care plan included decreased medication and seeking chair pressure pad alarm.</p> <p>Resident 9 has not fallen since 06/08/2015 with intervention reviewed at Nurses Staff meeting. Resident 9 assessed and care plan revised. Interventions added include medication change and use of short backed dining room chair.</p> <p>Resident 7 care plan reviewed and revised with the addition of a toileting plan intervention.</p> <p>Each resident identified as at risk for fall at admit, with a change of condition, at quarterly assessment, or with history of previous falls will have care plan reviewed/revise to include interventions currently in use to reduce falls.</p> <p><i>by change nurse at time of fall 11/5/2015</i></p> <p>Review of care plans and interventions will be completed at monthly fall committee meetings to ensure appropriate fall prevention interventions are in place.</p>	10/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 7</p> <p>causing involuntary [unable to control] movements caused by long-term use of psychoactive medications), constipation, and dementia (memory and decision making problems).</p> <p>Random observations from 9/1/15 through 9/2/15 revealed resident 9: *Used a walker and one staff person for assistance to walk. *Spent a lot of time in the recliner in the dining room by the bird cage. *Did not have a falling star sticker (used to identify residents as fall risk) by her door or on her walker.</p> <p>Interview on 9/2/15 at 10:50 a.m. with medication aides/certified nursing assistants (CNA) D and E regarding resident 9 revealed: *She was supposed to walk with a walker and staff assistance. *She attempted to walk on her own at times. *She had not fallen for a few months but had a history of falls. *She should have had a falling star sticker on her door or walker. *The falling star sticker indicated the resident was a high fall risk. *The Minimum Data Set (MDS) coordinator usually put the stickers on the residents' doors.</p> <p>Review of resident 9's Fall Follow-Up progress notes by nursing revealed falls and the prevention methods regarding future falls on the following dates: *12/5/14, fell in her room with a head injury. -She had attempted to transfer herself. -She had a short term memory problem. -Prevention: "Reminded to ask for assistance.</p>	F 323	<p>F323</p> <p>Eduction will be provided to nursing staff on the following:</p> <ol style="list-style-type: none"> 1. Fall Prevention Policy 2. Fall follow-up process to include toileting assessments and neurological assessments. 3. Documentation that appropriate that appropriate fall prevention interventions are completed. <p>Monthly audits will be completed by Director of Nursing (DON) or designee for all fall follow ups to identify that pain and/or neurological assessments were completed, if appropriate. Audits will also include the review of care plans to ensure appropriate problem areas and interventions are in place. Audits will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee by Director of Nursing or designee until advised to discontinue by the committee.</p> <p>Reviewed with nursing staff meeting which residents require TABS (basic tool for fall management) monitors and when/how placed on the resident. Will review TABS monitor placement at Fall Prevention Committee.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 8</p> <p>Staff to anticipate needs as much as possible. She is very independent with most things and sometimes does not allow staff to assist her." *12/15/14, had a witnessed fall in the hallway and hit her head. -She had a short term memory problem. -She was sent to the hospital for evaluation. -Prevention: "TABS [type of monitor that alerts staff when a resident moves] alarm placed on bed, and will be applied to wheelchair and recliner when in those. To use wheelchair more than walker, with staff assist." *12/31/14, fell in the dining room with no injury. -She had been turning with staff assistance and fell backward. -Prevention: "Continue to assist with ambulating [walking]." *1/30/15, fell in her room and hit her head. -She had removed her TABS alarm and gotten up by herself. -Prevention: "Use tabs monitor already, it was in place and she ripped it off and proceeded to try and get herself out of bed. she had already been toileted as well X [times] 3 since she was put to bed after lunch." *3/9/15, fell within the dining room and hit her head. -She was witnessed falling and had been told to wait for assistance prior to that. -Prevention: "Always ambulate with resident. Use a gait belt. Use a walker. Tabs alarm." *3/20/15, fell in the dining room and hit her head. -She was witnessed attempting to transfer herself. -Prevention: "Anticipate [resident's name] needs and assist with leaving the table." *4/4/15, fell in the dining room with no injury. -She was lowered to the floor by nursing staff. -The right side of the dining chair broke when it</p>	F 323	<p>F323</p> <p>Nursing staff can remind a moderate or severe cognitively impaired resident to use the call light, but it should not be used as the only intervention. Will review with nursing staff which residents are cognitively impaired. Will pursue purchase of motion sensors and chair alarm pads to use in place of TABS, if TABS are not preventing falls for a resident.</p> <p>The facility will also reach out to the South Dakota Foundation for Medical Care for potential resources related to falls, alarm management, and QAPI tools.</p> <p>The Fall Prevention Policy was updated. Fall Interventions and Post Fall Checklist was instituted for reference by the nursing staff. <i>*After all nurses were educated. JH/SPO/KEL</i> A QAPI study will be conducted to ensure falls for the past week are reviewed at the Fall Prevention Committee Meeting weekly with appropriate interventions to reduce falls by the Long Term Care Nursing Coordinators or designee and monitored by Director of Nursing or designee to be reported to the QAPI quarterly meeting until the QAPI Committee advises to discontinue.</p> <p>Instruction manuals for mechanical lifts have been printed off. Director of Maintenance has instituted a monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 9</p> <p>tipped with her.</p> <p>-Prevention: "Seek new chair that slides when she pushes self back."</p> <p>*6/8/15, fell in the dining room and struck her left elbow.</p> <p>-She had a hematoma (swelling with bruise) on her left shoulder.</p> <p>-She had a broken left humerus (arm).</p> <p>-Prevention: "Staff to not take her to the table until meal is to be served as will not wait for assist."</p> <p>Review of resident 9's 7/22/15 care plan revealed:</p> <p>*She had short and long term memory problems and impaired decision making.</p> <p>*She required extensive assistance of one staff person with moving in bed, walking, dressing, personal hygiene, and using the toilet.</p> <p>*She was at high risk for falls, and she had a history of falls with a broken left humerus.</p> <p>*Interventions for falls included:</p> <p>- "Assess for acute med [medical] conditions."</p> <p>- "Assess for environment."</p> <p>- "Keep area properly lighted."</p> <p>- "Keep obstacles out of the way."</p> <p>- "Keep area calm and try to prevent distractions."</p> <p>- "To sit in regular dining room chair not high back chair at the table as she pushes chair back at times and regular chairs are stronger."</p> <p>- "Anticipate needs."</p> <p>- "Take to recliner chair in dining room as soon as done eating so she does not attempt to go by herself."</p> <p>- "Use TABS monitor when in bed."</p> <p>- "Be aware that she does not use call light but calls out for nurse when she wants something."</p> <p>*Those interventions had been initiated on 2/25/14.</p>	F 323	<p>F323</p> <p>checklist for maintenance in order to maintain lifts.</p> <p>It is the responsibility of the nursing staff to notify maintenance of any concerns that may arise with the lifts between the timeframe of the monthly maintenance checks.</p> <p>An assessment of the mechanical lifts was conducted.</p> <p>Safety tabs were ordered.</p> <p>QAPI study will be performed by maintenance staff or designee monthly x 3 months and monitored by the Director of Maintenance or designee.</p> <p>The study will be reviewed at the quarterly QAPI meeting until committee advises discontinuing.</p> <p>Two (2) portable radios are being used. A Two-Way Radio Policy was developed and instituted.</p> <p>We will purchase three (3) sets of radios for nursing staff to carry during breaks on days and all night whenever one (1) staff member is in the Oahe Haven.</p> <p>QAPI study to check radio use weekly for 3 months and will be completed by the Charge Nurse or designee and monitored by Director of Nursing (DON) or designee monthly.</p> <p>Reported by DON or designee at QAPI Committee until advised to discontinue.</p>	<p><i>who were educated at the all staff meeting are JH/SDDOK/EL</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442
---	---

(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 323	<p>Continued From page 10</p> <p>2. Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 2/20/12. *She was alert but forgetful. *Her diagnoses included high blood pressure, low potassium (can affect muscles), psychosis (mental disorder causing changes in thinking and emotions), atrial fibrillation (problem with heart rhythm) history of urinary (bladder) tract infections, shortness of breath, and dizziness. <p>Observation and interview on 9/1/15 at 9:25 a.m. of resident 1 revealed:</p> <ul style="list-style-type: none"> *She was sitting in her recliner in her room with her feet up. *She was alert, pleasant, and oriented to person and place. *There was a TABS alarm sitting on the foot of her bed that was not attached to her clothing. *She stated she did not get up on her own; she would use the call light to get the staff to help her if she needed something. -The call light was within reach. <p>Observation during the medication administration for another resident on 9/1/15 at 10:30 a.m. with RN C revealed:</p> <ul style="list-style-type: none"> *Resident 1 was walking in the hallway by herself. *RN A stated "Oh I don't like that. She's not supposed to be up by herself." *After she finished preparing the other resident's medication she closed the medication cart. *She went into that other resident's room across the hall and administered the medication. *When she came back out of that room approximately thirty seconds later, resident 1 was lying on the floor on her left side. *Resident 1 had hit her head and was bleeding from lacerations by her left eyebrow and left 	F 323		
-------	---	-------	--	--

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 11</p> <p>elbow.</p> <p>*RN C assessed the resident.</p> <p>*RN C, with the help of medication aides/CNAs D and E, and the resident care coordinator nurse assisted the resident into a wheelchair and back to her room.</p> <p>*Once resident 1 was in her room nursing staff continued their assessment.</p> <p>Interview with medication aide E at the time resident 1 was brought back into her room after the fall revealed:</p> <p>*She should have had the TABS alarm put on her when she was in her recliner.</p> <p>*She was unsure who had put her into the recliner after breakfast.</p> <p>*Anyone who had seen the resident walking by herself should have stopped to help her right away to prevent her from falling.</p> <p>*She could have walked with staff assistance but not by herself.</p> <p>Interview on 9/1/15 at 10:45 a.m. with the director of nursing (DON) confirmed resident 1 should not have been walking by herself if she had a TABS alarm.</p> <p>Interview on 9/1/15 at 10:46 a.m. with the Minimum Data Set (MDS) assessment nurse regarding resident 1 revealed:</p> <p>*She had been the one who had brought her back to her room after breakfast around 9:00 a.m.</p> <p>*She had assisted her into the recliner, had put the TABS alarm on the back of the chair, and had clipped it to the resident's shawl.</p> <p>*She thought the resident probably had removed the TABS alarm on her own.</p> <p>*She had been removing the TABS monitor on her own and had recently cut the strings with a</p>	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 12</p> <p>scissors in her room. *They had removed the scissors. *She agreed they should have probably tried something different than the TABS alarm since she was removing it and cutting the strings. *She confirmed if a staff member had seen the resident walking by herself they should have helped her right away. *She agreed the resident needed assistance with walking.</p> <p>Further interview on 9/1/15 at 11:45 a.m. with the MDS nurse revealed she: *Had taken the resident's scissors away the day before. *Had not documented that the resident had cut the strings of the TABS alarms, or the scissors were taken from her room.</p> <p>Interview on 9/1/15 at 11:45 a.m. with RN C confirmed: *She should have taken resident 1 back to her room right away when she had seen her walking by herself. *She might have prevented resident 1's fall that morning.</p> <p>Review of resident 1's Fall Follow-Up progress notes by nursing revealed falls and the prevention methods regarding future falls on the following dates: *6/11/15, fell in her room and obtained a bruise on her right elbow. -She had attempted to transfer herself. -She had a short term memory problem. -Prevention: "Remind resident to use call system for help." *7/1/15, fell in her room and obtained a skin tear on her left elbow.</p>	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 13</p> <ul style="list-style-type: none"> -She had a short term memory problem. -Prevention: "Making sure bed is in proper position and call light within reach." *8/9/15, fell in her room and obtained skin tears on both arms and a bruise on her left knee. -Prevention: "Call for assist." *8/10/15, fell in her room with no injury. -She had a short term memory problem. -Prevention: "Keep encouraging her to use call light and check her often." *8/17/15, fell in her room with no injury. -She had a short term memory problem. -Prevention: "Continue to use tabs monitor, toilet on rounds, anticipate needs." *9/1/15, fell in the hallway and hit her head. She obtained skin tears to her left eyebrow and left elbow. -She was witnessed attempting to transfer herself. -She had a short term memory problem. -Prevention: "When standing in hallway take to room immediately." <p>Review of resident 1's 7/1/15 care plan revealed:</p> <ul style="list-style-type: none"> *She had mild cognitive (memory, thinking) loss. *She required extensive assistance of one staff person with dressing, personal hygiene, and using the toilet. *She required assistance of one staff person with walking in her room and the hallways. *She was at high risk for falls. *The last fall was written in as 8/17/15. *The interventions for falls included: <ul style="list-style-type: none"> -"Medication Review by provider with each visit." -"Pharmacy consultant review monthly." -"Monitor for side effects" of medications. -"Seek dose reduction when appropriate" of medications. -"Monitor for mood and behavior." 	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 14</p> <p>*Handwritten entries of: -"Call for assist - call light in reach." -"TABS monitor to bed and wheelchair." *There were not specific interventions for all the falls.</p> <p>Surveyor 32573 3. Review of resident 7's complete medical record revealed: *She had sixteen falls total 7/23/14 through 9/2/15. *She had hit her head twice. *She had been trying to use the restroom herself on several occasions when she had fallen. *She had been left alone on a lift in the bathroom and had fallen out of it on 3/12/15.</p> <p>Review of resident 7's fall reports revealed the following fall information and interventions to prevent future falls: *7/23/14, found sitting on the floor in her room. -Interventions: monitor closer, can not use tabs alarm because the resident removes it, and she does not understand to use the call light. *8/31/14 at 9:00 p.m., found sitting on the floor in her room. -Interventions: offer assistance to bathroom and remind her to call for help. *9/30/14 at 4:10 p.m., fell on her back when an aide left her to get her wheelchair (w/c). -Interventions: monitor closer and call for assist and not leave her to get w/c. *10/5/14 at 1:58 p.m., found incontinent (loss of bladder or bowel control) on the floor in her room, so suspected she had been trying to go to the bathroom. -Intervention: resident had been educated to wait for assistance and she needed reinforcement for understanding.</p>	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 15</p> <p>*10/14/14 at 5:05 p.m., found on the floor by her bed with a small mark on her back. -Intervention: resident educated to wait for assistance, and needed reinforcement for understanding.</p> <p>*12/21/14 at 8:18 p.m., found sitting on the floor in her room facing the bathroom. -Intervention: tabs alarm on while in her w/c.</p> <p>*1/21/15 at 12:59 p.m., walking herself with her walker and fell backwards on her back and buttock resulting in thigh and hip pain. -Intervention: educated to wait for assistance, and needed reinforcement for understanding.</p> <p>*1/22/15 at 2:55 p.m., trying to go to the bathroom by herself and fell. -Interventions: anticipate resident's needs and take her to the bathroom around 2:30 p.m. or so.</p> <p>*3/12/15 at 10:58 a.m., tried to get up in the dining room, slid down to the floor without injury, and was taken to the bathroom. -Interventions: give her a magazine to occupy her time, allow her to sit on the toilet longer before getting up, and to monitor her bowel movements (BM).</p> <p>*3/15/15 at 11:20 a.m., had been hooked into a lift in the bathroom over the toilet. The certified nursing assistant had left her on the lift, and when she returned the resident had been on the floor in the sling of the lift. -Interventions: follow current plan of care and to not leave her alone on the lift.</p> <p>*3/16/15 at 7:00 p.m., found on the floor between her w/c and bed. -Interventions: reinforce the need to get assistance from staff and to not allow her in her room until staff were ready to place her in bed.</p> <p>*3/22/15 at 2:23 p.m., found on the floor in her room with the tabs alarm sounding. -Interventions: continue care as outlined in care</p>	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 16</p> <p>plan.</p> <p>*5/21/15 at 8:09 p.m., witnessed sliding out of her w/c.</p> <p>-Intervention: remind resident not to try to stand alone.</p> <p>*5/24/15 at 2:12 p.m., was witnessed slipping out of her w/c and hit her head.</p> <p>-Interventions: monitor closely and remind her to sit up straight in her w/c.</p> <p>*7/15/15 at 1:30 p.m., found on her back, in her room with the tabs alarm going off. She had a large bump on her forehead.</p> <p>-Intervention: continue to monitor, and try to keep her out of her room so staff could monitor her better.</p> <p>Review of resident 7's 6/15/15 Minimum Data Set (MDS) assessment revealed:</p> <p>*A brief interview for mental status score of five, indicating she was severely cognitively (ability to understand) impaired.</p> <p>*She was occasionally incontinent of bladder and frequently incontinent of bowel.</p> <p>-She was not on a toileting plan.</p> <p>Review of resident 7's current care plan revealed she was at high risk for falls.</p> <p>*In the fall section:</p> <p>-On 7/15/15 had fallen and hit her head.</p> <p>-A 7/15/15 goal, tabs alarm (device used to help prevent falls) at all times.</p> <p>-An intervention, remind her to wait for assistance.</p> <p>-An intervention, give her reading material, so she will stay in the dining room.</p> <p>*No other falls had been noted on her careplan.</p> <p>*No other interventions had been listed on her careplan.</p> <p>*In the continence section she had urinary</p>	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 17</p> <p>incontinence and received assistance to go to the bathroom.</p> <p>-A 3/25/14 goal, would accept assistance to toilet to prevent falls.</p> <p>-Intervention, toilet on rounds.</p> <p>-Intervention, staff to toilet her during the night and in the morning to prevent falls.</p> <p>Interview on 9/2/15 at 10:40 a.m. with nurse F revealed:</p> <p>*Staff did not document every time they toileted a resident.</p> <p>*Resident 7 was toileted every day.</p> <p>*Toileting was only documented during quarterly care planning.</p> <p>*There were no specific toileting programs in the facility.</p> <p>*She said staff had left resident 7 alone on the lift on 3/15/15, because they had been trying to prevent another resident fall.</p> <p>Surveyor 35237</p> <p>4. Review of the Nurse's Staff Meeting notes from August 2014 through August 2015 revealed falls had been discussed in:</p> <p>*September 2014:</p> <p>-They mentioned the number of falls from August, and one resident who was at high risk.</p> <p>*December 2014:</p> <p>-They mentioned the process for neurological (nervous system) checks if a resident hit their head during a fall and the number of falls from November.</p> <p>-There were hand outs for "10 Questions at the Time a Resident Falls", "Risk Factors/Contributing Factors for Falls", and "Fall Risk for Injury - ABCs attached."</p> <p>*January 2015:</p> <p>-They mentioned the number of falls from</p>	F 323			

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER avera oahe manor	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442
---	---

(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 323	<p>Continued From page 18</p> <p>December 2014 and three residents who had two falls each.</p> <p>*February 2015: -They mentioned the number of falls from January and two residents who had two and three falls each. -There were notes for possible fall prevention ideas for one of those two residents.</p> <p>*March 2015: -They mentioned the number of falls from February and one resident who had three falls.</p> <p>*May 2015: -They mentioned the number of falls from April and two residents who had two and three falls each. -There were notes for possible fall prevention ideas for those residents.</p> <p>*June 2015: -They mentioned the number of falls from May and one resident who had two falls. -There were notes for possible fall prevention for that resident.</p> <p>*July 2015: -There was a note that stated "Number of falls in June decreased to 6. Mostly due to deaths of specific residents." *Falls were not mentioned in August, October, or November 2014, or April and August 2015. *Only specific residents had been discussed for prevention ideas in the above months not all residents.</p> <p>Interview on 9/2/15 at 9:15 a.m. with the DON regarding falls revealed: *They were talked about at the quarterly risk management meetings. *They did not discuss them at the quarterly quality assurance performance improvement (QAPI) meetings.</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER avera oahe manor		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 19</p> <ul style="list-style-type: none"> *There was no fall committee. *They would follow their fall prevention policy. <p>Interview on 9/2/15 at 3:50 p.m. with the DON, interim administrator, and new administrator regarding falls revealed:</p> <ul style="list-style-type: none"> *The DON was aware the facility flagged high for falls on their quality measures reports. *There was no fall committee; she felt they maybe needed to have one. *Falls would have been discussed sometimes during MDS or care plan meetings and at the monthly nursing meetings. -They would have identified the number of falls, but not what had happened to cause those falls. *Last year they had worked on falls as part of QAPI, but it was not on the 2015 goals. *The DON felt the facility had fewer falls with major injury but still a high number of total falls. *They agreed they needed to do more education with the staff related to falls. *There were no residents on individualized toileting programs in the facility. -Residents were taken to the toilet per the facility standard times (before and after meals, at bedtime, night rounds, and as needed). *Fall interventions to prevent future falls were decided by the nurse at the time of the fall. -No one reviewed those interventions to make sure they were appropriate. *Care plan updates/revisions should have been done by the nurse after a fall. -There should have been interventions on the care plan for each fall, not just the date of the fall listed. *They agreed: -Fall interventions should have been individualized for each resident. -There were a lot of different interventions that 	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER avera oahe manor		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 20</p> <p>could have been tried to prevent falls.</p> <p>-Encouraging or reminding a resident with cognitive impairment to use the call light was not an appropriate intervention.</p> <p>-There was a problem with the system related to falls in the facility.</p> <p>*The DON stated they were still using the falling stars (sticker to alert staff of resident's at risk for falls) program per their policy.</p> <p>-Residents 1 and 9 should have had falling star stickers by their doors.</p> <p>-The MDS nurse usually put the stickers on the doors of those residents identified at high risk for falls.</p> <p>Review of the provider's February 2007 Fall Prevention policy revealed:</p> <p>*The purpose was "to identify residents and patients who are at risk for falling by educating employees and families. To institute preventative interventions, outlining communication and documentation."</p> <p>***The Director of Nurses, Nursing Coordinators and Coordinator of Maintenance are responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment to aide in fall prevention. Registered Nurses are responsible for implementation and oversight of individualized resident fall prevention care including assessing fall risk upon admission, using the Morse Fall Scale in the hospital, reassessing residents for change in fall risks when a change in condition occurs and collaborating with the interdisciplinary team in the prevention of falls."</p> <p>***Notation should be made in the nurse's notes, including those factors which have placed the resident at risk for falls, patient response to event, evidence of injury, location, provider</p>	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 21</p> <p>notification and actions taken. If history of more than 3 falls in 3 months or the resident/patient is considered intermediate or high risk according to assessment, place a falling star at the room door, on the headboard, on the walker or w/c and on the care plans and reassess quarterly. The Falling Star Prevention Plan continues for the resident until the risk assessment falls below 5."</p> <p>***Contributing factors will be documented in the nurses' notes and in the communication book...Keep the room free of clutter. Chair, bed and room alarms are to be instituted at the discretion of the care plan team, physical therapy or the nurse. All staff will implement interventions to create a safe environment conducting environmental rounds.</p> <p>***The interdisciplinary care plan team will assess all factors contributing to a fall, such as the environment, equipment and medications. Changes to plan of care will be recommended."</p> <p>***Facility fall review is completed monthly and reported to staff for identification of high risk residents."</p> <p>Surveyor: 32355</p> <p>B. Based on observation, interview, and manufacturer review, the provider failed to ensure two of four randomly observed EZ Way Stands (mechanical lift used for transferring residents) had safety tabs per manufacturer's guidelines. Findings include:</p> <p>1. Random observations on 9/1/15 from 8:00 a.m. through 3:30 p.m. of two 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</p>	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 22 fallen from the mechanical lift.</p> <p>Interview on 9/2/15 at 7:50 a.m. with the maintenance supervisor revealed: *He had not been aware the mechanical lifts required safety tabs. *He did not have the mechanical lifts on a preventative maintenance program to ensure they were in proper working condition. *The provider had an outside contract with a company who came to the facility once a year to inspect and check on various items in the building. The mechanical lifts had been one of those items. *He was not sure what items the company checked on the mechanical lifts.</p> <p>Review of the provider's December 2014 Maintenance/Engineering of Existing procedures confirmed the mechanical lifts had not been listed as an item to be routinely inspected and checked to ensure proper working condition.</p> <p>Review of the surveyor's copy of the 6/17/14 EZ Way Smart Stand Operator's Instructions Manual 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." *Recommendations were suggested to inspect the mechanical lifts every month. **"Any detected deficiency must be rectified before the stand is put back into service." **"Safety tabs need to checked to make sure they are in place."</p> <p>The provider did not have the above operator's instructions manual to follow.</p>	F 323		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 23</p> <p>C. Based on observation and interview, the provider failed to ensure all staff were educated on the paging system to be used during an emergency situation for one of one secured unit (Haven). Findings include:</p> <p>1. Random observations on 9/1/15 from 7:30 a.m. through 5:30 p.m. of the Haven unit revealed were two staff members working in the unit except when they took their individual breaks.</p> <p>Interview on 9/1/15 at 10:00 a.m. with registered nurse (RN) A revealed: *There were two staff members working in the unit from 7:00 a.m. to 6:30 p.m. *During the evening and through the night time hours one staff member worked in the unit. *There would have been only one staff member working in the unit during break times.</p> <p>Interview on 9/1/15 at 10:40 a.m. with certified nursing assistant (CNA) B revealed: *The other staff member had left the unit for her break. *CNA B had been working in the unit by herself. *She would have pulled the call light cord located in the residents' rooms should an emergency have occurred. The call light would have sounded out at the main nurses' station. The call light would have alerted the staff members located at the nurses' station that assistance was needed in that room. *She had not been aware of any other paging or calling system in place to alert the other staff members when assistance was needed in the unit. *She could not guarantee there was always someone located at the nurses' station during times of an emergency to ensure assistance</p>	F 323			

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	<p>Continued From page 24 would have occurred.</p> <p>Interview on 9/2/15 at 10:50 a.m. with RNA revealed:</p> <ul style="list-style-type: none"> *The unit had walkie talkies (handheld radio device) located in the kitchen. *The staff in the unit should have used those walkie talkies to communicate with the staff out on the main unit. *The walkie talkies did not always work and required the batteries to be re-charged every two hours. *There had been no back-up walkie talkies for the staff members to use while the others were re-charging. *She had informed the director of nursing (DON) the walkie talkies did not always work. *She could not guarantee the staff in the unit and out on the main floor used the walkie talkies for communication as directed to by the provider. <p>Observation on 9/2/15 at 10:55 a.m. of the walkie talkies with RNA revealed:</p> <ul style="list-style-type: none"> *They had been located in the unit kitchen and were laying on the counter. *They had not been working and required re-charging. *She had not been able to confirm how long they had been uncharged. *She and the other staff member in the unit had not used them during their individual break times. <p>Interview on 9/2/15 at 1:45 p.m. with the DON regarding the paging system for the safety of the residents and staff when working in the secured unit revealed:</p> <ul style="list-style-type: none"> *There had been two sets of walkie talkies. One set had been located in the unit kitchen and the other at the nurses' station on the main unit. 	F 323			

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 323	Continued From page 25 *The nursing staff were to have used those walkie talkies to communicate with each other. *She had not been aware: -The nursing staff were not using them at all times. -They were not always working correctly. *She would have expected the staff to be using the walkie talkies as directed by the provider. The provider was not able to provide a policy and procedure regarding the paging system required to be used in the secured unit during emergency situations.	F 323			
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. (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	F 441	F441 Blankets, combs, brush, nail clippers and files were removed from the closet and drawers on the day of the survey. Personal items will be stored in the resident room with their name on items or placed in the wash after one use. Storage of Personal Items Policy was developed and instituted and reviewed at the All Staff Meeting. A Quality Assurance and Performance Improvement (QAPI) study to check closets and drawers weekly for personal items to be completed by the Certified Nursing Assistants (CNA's) and monitored by the Haven Nursing Coordinator or designee ^{weekly} and reported to Director of Nursing (DON) or designee ^{monthly} who will report at <i>JH/SDDOK/EL</i>	10/22/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 26</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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 and interview, the provider failed to ensure sanitary conditions were maintained for residents' personal care items in one of one secured unit (Haven). Findings include:</p> <p>1. Observation on 9/1/15 at 7:30 a.m. of the Haven unit revealed: *A family room with several chairs and a large closet. Inside of the closet there were five blankets. Those blankets had been co-mingled (mixed) together. No resident names had been identified on any of the blankets. *A large cupboard in the dining/activity room area with several drawers. One of those drawers contained multiple residents' care items mixed together that included combs, a brush, fingernail clippers, and fingernail files. The brush had a large amount of white/gray colored hair attached to it.</p>	F 441	F441 the quarterly QAPI Committee meeting until committee advises to discontinue.	

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 27 Interview on 9/2/15 at 10:50 a.m. with the Haven unit coordinator revealed: *She could not identify who the unmarked blankets belonged to. *The blankets had been used to cover the residents when they rested in the chairs. *She did not know if the blankets had been washed or if they were clean. *She agreed the blankets should have been marked with the resident's name and not stored together. *They should have been stored in each of the resident's rooms to whom they belonged. *She removed the blankets from the closet. *She had been unaware of the personal care items in the cupboard drawer located in the dining/activity room. She could not identify who they belonged to. They should have been marked and stored in the residents' rooms. *She agreed the observations above had created the potential for infections from bacteria to spread from one resident to another. The provider had not given the surveyor a policy and procedure for the proper storage of resident personal items prior to leaving the facility.	F 441			
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520	F520 The Quality Assurance Performance Improvement (QAPI) plan was reviewed and revised. The QAPI program will include review of resident care concerns and plans, identify trends in the quality indicator measures, identify trends and tracking of resident falls, identify needs and issues with electronic medical	10/22/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 520	<p>Continued From page 28</p> <p>issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and policy review, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns and to develop and implement corrective action for residents with falls. Findings include:</p> <p>1. Review of the provider's QA meeting notes from 7/2/14 through 6/30/15 revealed falls had been discussed in two of the five meetings. The number of falls had been monitored. There had been no fall monitoring documented in 2015. There had been no documentation that falls had been investigated. There had not been corrective measures put in place by the provider to help minimize falls in the facility. Any current corrective measures in place for preventing falls had not been monitored by the provider for effectiveness.</p> <p>Interview on 9/2/15 at 3:50 p.m. with the director</p>	F 520	<p>F520 records, discuss new and old policies and procedures, discuss monthly pharmacist reports, discuss incident and safety reports, discuss staff concerns and needs.</p> <p>QAPI Committee meetings will be held at a minimum of quarterly consisting of the Administrator, Director of Nursing, Medical Director and at least 3 other members of the facility staff.</p> <p>Re-establish falls as a priority in the Quality Assurance Performance Improvement (QAPI) plan with meetings quarterly. All resident falls will be addressed, care plans reviewed with appropriate interventions by nurse at the time of fall. This will be reviewed at Daily Lineup every day at 9:00 am by Directors and Coordinators.</p> <p>The Fall Prevention Committee meeting weekly will assess residents at risk for falls for the past week. The Committee will make further suggestions and monitoring of interventions for effectiveness. Will also receive input from monthly Nurses Staff Meetings on corrective actions and monitoring in more detail. Falls will be a quality indicator in Long Term Care to be reviewed by the QAPI Committee quarterly and monitored</p>		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 520	<p>Continued From page 29 of nursing revealed: *She was responsible for the provider's QA program. *She was aware the facility had a lot of falls. *She believed there had been less falls with major injury since the 2014 QA studies about falls. *She thought what they had done in 2014 had been enough but agreed there could be more monitoring done. *Falls were discussed in nursing meetings, but monitoring and corrective actions had not been done.</p> <p>Review of the provider's October 2012 Plan-Do-Check-Act-Cycle (PDCA) quality management approach policy revealed the following steps to take to solve problems: *Plan, identify and analyze a problem and get to the root cause. *Do, find best solutions and test those solutions. *Check, measure how effective a test solution had been and look for ways to improve. Measure results. *Act, fully implement the most effective solution. *Repeat the above cycle for continuous improvement.</p> <p>Review of the undated Quality Improvement (QI) plan revealed the methodology (procedure) of the quality improvement program had included: *Problem identification, data examined. *Problem assessment, assessment findings. *Problem resolution, action and follow up. *One of the goals of the QI plan was to establish priorities for investigation and correction of problems that impacted direct or indirect resident care and to protect residents from adverse outcomes.</p>	F 520	<p>F520 by the Director of Nursing or designee until QAPI Committee advises to discontinue.</p> <p>QAPI education was provided to all staff through department meetings including the 5 Elements, Performance Improvement Projects, Systematic Analysis and Action. Will revise and review QAPI Plan to incorporate QAPI elements.</p> <p>Will reach out to South Dakota Foundation for Medical Care to assist with QAPI resources.</p>		

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 520	Continued From page 30 Refer to F323, findings 1, 2, 3, and 4A.	F 520			

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

ORIGINAL

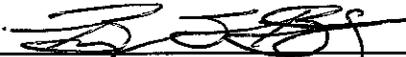
PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/1/15. Avera Oahe Manor 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 upon correction of deficiencies identified at K011 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 10/2/15 per telephone per Administrator and Director of Fiscal Services. LF/SDDO#/EL	
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain one of one ninety minute fire rated door in the two hour fire rated common wall separating the non-conforming clinic building from the nursing home. Findings include: 1. Observation at 11:10 a.m. on 9/1/15 revealed a ninety minute fire rated door in the two hour fire	K 011	K011 Vendor was contacted that panic bar on door separating the clinic from the nursing home needed replaced. New hardware was ordered and will be installed upon receipt. Administrator approved vendor to order new hardware as reviewed by Medical Facilities Engineer on 09/22/2015. *The director of maintenance will monitor and review the vendors work upon completion and will report to the QA committee. LF/SDDO#/EL	10/22/2015

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

TITLE

(X6) DATE



Interim Administrator

9-24-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 011	Continued From page 1 rated wall separating the clinic from the nursing home. The latching hardware and panic bar for that door was not listed as fire rated. The panic bar was equipped with a feature that was capable of disengaging the latching hardware. All door hardware for fire rated doors should have been equipped with listed fire rated latching hardware that is not provided with a feature to disengage the latching mechanism. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he had not noticed the latching hardware disengage feature on the door hardware. He indicated he was not familiar with the listed fire rated hardware requirement. He did not indicate that hardware had been replaced at any time. That door hardware appeared to original to the door when installed.	K 011			
K 062 SS=C	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: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition and inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings	K 062	K062 September 17, 2015, the Director of Maintenance and maintenance personnel called Building Sprinkler to inform them we need a five year internal obstruction investigation completed on the sprinkler system in our secured unit. Building Sprinkler will be on-site to perform this investigation on September 29, 2015. Verification will be forwarded upon completion. Inspection will be added to the preventative maintenance checklist. <i>* The director of maintenance will review the inspection reports upon completion and will report the findings to the QA committee.</i>	10/22/2015	

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

PRINTED: 09/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2015
NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD GETTYSBURG, SD 57442		
(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 2 include: 1. Document review at 9:50 a.m. on 9/1/15 of the provider's automatic sprinkler system inspection report prepared by Building Sprinkler Inc. revealed no documentation of the required five year internal obstruction investigation. The automatic sprinkler was installed with the original construction of the secure unit addition in 1997. Approximately thirteen years had lapsed since the last internal obstruction investigation should have been completed. Interview with the plant operations supervisor at the time of the record review confirmed that condition. He indicated he was unaware of the five year internal obstruction investigation.	K 062			

ORIGINAL

PRINTED: 09/16/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD AVE GETTYSBURG, SD 57442
---	---

(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	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/31/15 through 9/2/15. Avera Oahe Manor was found not in compliance with the following requirement: S165.	S 000		
S 165	44:04:02:17 OCCUPANT PROTECTION Each licensed health care facility covered by this article must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the... residents admitted to the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the electrically activated audible alarm at one of seven marked exit doors to the exterior (main entrance). Findings include: 1. Observation at 2:00 p.m. on 9/1/15 revealed the main entrance door was equipped with an audible alarm. That alarm was not activated at the time of observation and only activated during the evening hours from 11:00 p.m. to 8:00 a.m. The main entrance was within sight distance from numerous staff offices and the main nurses station. That exit door would classify as being monitored during the general office hours. However during the times when administration	S 165	S165 As of 09/21/2015, main entrance front door alarm will be activated at 5:00 pm to 8:00 am. Staff training was held. The Door Alarm Policy was reviewed and revised. Keys to front door discarded. Maintenance disabled locking mechanism. Director of Resident Care or designee will perform Quality Assurance and Performance Improvement (QAPI) study weekly x 3 months and will be monitored by Director of Nursing (DON) or designee and reported to the quarterly QAPI Meeting until committee advises to discontinue.	10/22/2015

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

TITLE

(X6) DATE

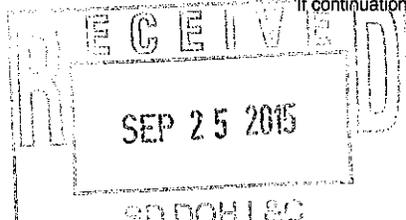
Interim Administrator

9-24-15

STATE FORM

6899

TQE711



If continuation sheet 1 of 3

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD AVE GETTYSBURG, SD 57442
---	---

(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 165	<p>Continued From page 1</p> <p>staff leaves at about 5:00 p.m. that door would no longer be considered monitored.</p> <p>Interview with the director of maintenance at the time of the above observation revealed the audible alarm was activated during the hours of 11:00 p.m. to 8:00 a.m. during the evening hours.</p> <p>Further interview during the exit interview with the director of nursing at 2:30 p.m. on 9/1/15 confirmed that the alarm was activated from 11:00 p.m. to 8:00 a.m. She also confirmed that the door would not be considered monitored during the hours of 5:00 p.m. to 11:00 p.m. The provider's policy for door alarms shall be updated to ensure that audible alarm for the entrance door is activated as soon as administrative staff leave for the day or any other time when the main door would not be considered monitored.</p> <p>2. Observation at the same time above of that door revealed that door was equipped with a keyed deadbolt lock. The lock was not engaged at the time of observation. That lock did not meet life safety code standards and should not be used.</p> <p>Interview with the director of maintenance at the time of the above observation revealed she believed that door was locked at night to prevent unauthorized visitors during the evening hours.</p> <p>Further interview during the exit interview with the director of nursing at 2:30 p.m. on 9/1/15 revealed the director of maintenance was mistaken. That door was not locked during the evening hours and that lock was not used. It was further reiterated that the keyed deadbolt lock shall not be used as it does not meet life safety code standards for egress requirements for a</p>	S 165		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER AVERA OAHE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E GARFIELD AVE GETTYSBURG, SD 57442
---	---

(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 165	Continued From page 2 marked exit egress door.	S 165		