

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

ORIGINAL

PRINTED: 06/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 06/01/15 through 06/03/15. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F314, F323, and F431.	F 000	Addendums noted with an asterisk per 7/13/15 telephone to facility Interim Director of operations and Don. <i>SB/SDDH/JJ</i>	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Consistently communicate with the physician regarding one of one sampled resident (5) who had been admitted with an open area and developed another open area. *Revise approaches for wound care for one of one sampled resident (5). Findings include: 1. Review of resident 5's medical record revealed:	F 314		

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

TITLE

(X6) DATE

Bob Suttle

Regional President

6-25-15

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.

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F 314	Continued From page 1 *She had been admitted on 8/4/14. *Her admission assessment indicated she had a 0.5 centimeter (cm) by 0.5 cm open area to her right buttock. *A family member had reported the use of a barrier cream (applied to the skin to protect it from infection or moisture) for protection. *There had been no physician's orders for treatment of the open area on admission. *On 8/19/14 the area to the right buttock had been documented as a dry, scaly area. Barrier cream was applied after toileting. *Skin assessments from 8/19/14 through 1/26/15 indicated the right buttock wound was scabbed over. *On 2/2/15 the right buttock had opened up at 0.6 cm, with a depth of 0.1 cm. The staff continued to use barrier cream. *On 2/4/15 the nurse documented a 0.6 cm open area to her left buttock with a small amount of bloody drainage. The staff began using Sure Prep (a liquid that dries on the skin as a barrier film to protects skin). *On 2/5/15 the resident saw the physician regarding the open areas to the right and left buttocks. The physician had diagnosed "superficial ulceration" and ordered cushion and tape applied to the areas to prevent them from rubbing together. *On 2/6/15 the physical therapist (PT), a member of the provider's wound management team, called the physician to obtain approval to change orders back to the skin prep. The PT documented the physician's nurse had approved the skin prep use daily and to have the nurse monitor the areas daily. The nursing staff were to contact the PT department of any concerns or issues. *Nursing skin assessments on 2/9/15, 2/16/15, and 3/2/15 indicated a 1 cm open area to the right	F 314	F 314 The corrective action includes a review and revision of Policy 6312.29 Pressure Ulcer Prevention and Wound Treatment by the Director of Nursing (DON), the medical director, and the interdisciplinary team. A directed in-service review for nurses, nurse aides, and Certified Nurse Assistants (CNAs) on this policy will be conducted [*] by the DON or assistant DON by 7/2/15. SB/SOAH/JJ Compliance with following this policy will be monitored by nurses delegated to complete a monitoring tool designed to observe for staff compliance in the prevention and treatment of pressure ulcers and other wounds. [*] _____ every 2 weeks by SB/SOAH/JJ Four ← pressure ulcer prevention/treatment SB/SOAH/JJ	7/2/15 * SB/SOAH/JJ

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F 314	Continued From page 2 buttock. *On 3/9/15 the skin assessment indicated two 1 cm open areas to the right buttock. *On 3/23/15 the skin assessment indicated open areas to the left and right buttock. *On 4/6/15 the skin assessment indicated a 1 cm open area to the right buttock with bloody drainage. *From 5/4/15 through 5/18/15 skin assessments indicated open areas to the right and left buttocks. *On 6/1/15, the skin assessment indicated two small (1 cm) areas to the right buttock and one 1 cm area to the left buttock. *With each nursing skin assessment since 2/5/15, the staff had been applying the Sure Prep and a barrier cream. *Physician documentation of the skin wounds were only: -2/4/15 for the cushion and tape dressing. -No further changes in skin treatment. -5/13/15 indicating recurring superficial butt ulcerations "due to patient picking at the sites. Protocol by the staff does resolve these; then the patient resumes the picking-and that is a chronic un-resolvable issue for her." Review of her updated 5/20/15 care plan revealed approaches for: **"Monitor skin with all opportunities and notify the charge nurse of any new areas of breakdown. *Weekly head-to-toe skin observation by the licensed nurse. *Provide the resident with protective undergarments. *Assist with toileting so moisture barrier is being applied routinely. *Pressure redistribution using a pressure redistributing cushion in the recliner and a	F 314	An order for an electronic long term care (eLTC) wound consult, from resident 5's physician, was obtained on June 3, 2015. This consult was performed with an order to continue current treatment. An additional consult was conducted June 11, 2015 to reevaluate the wound with new recommendations and orders obtained. Plan of care for resident 5 will be amended for frequency of monitoring of wounds and additional preventative measures as discussed with Medical Director.	* [REDACTED] SB/SDDH/JJ * [REDACTED] SB/SDDH/JJ * [REDACTED] SB/SDDH/JJ	

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F 314	Continued From page 3 pressure redistributing mattress." Interview on 6/2/15 at 5:15 p.m. and on 6/3/15 at 7:45 a.m. with the assistant director of nursing (ADON) regarding resident 5 revealed: *The buttock wounds were moisture-related. *The two buttocks rubbed against each other causing open areas. *The physician had attempted to change the treatment of the buttock wounds in February. He had wanted to keep the buttock skin from rubbing against each other. *The wound care team did not feel the tape would have been beneficial and would have caused further breakdown. *The Sure Prep and barrier cream had assisted with healing the wounds in the past. **"Why would we change something that had worked before?" *The resident sometimes scratched at the wounds. -The staff had not attempted to trim her nails to prevent self-scratching. *The ADON normally rounded with the physicians, but resident 5's physician came too early in the morning, so she did not have contact with him. *Buttock wound dressings would have been difficult to keep clean. *The nurses had not contacted the physician for changes in treatment. *The staff had not attempted to reposition the resident to see if the wounds would improve. *The physical therapist had not evaluated her for positioning in her wheelchair. *The certified nursing assistants (CNA) were to have reminded the resident to call for assistance with toileting so they could apply the barrier cream and Sure Prep after she toileted.	F 314			

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F 314	<p>Continued From page 4</p> <p>*The staff had not attempted a toileting schedule to improve the moisture of the buttocks.</p> <p>*There were no wound specialists close by their facility.</p> <p>*The staff had talked of possibly having the resident treated by a wound specialist visually assessing the resident by remote camera over the Internet (E-Long Term Care tele-medicine).</p> <p>*The nurses assessed the wounds weekly.</p> <p>*The standard was: -The CNA would let the nurse know if the wound had changed. -The nurse was not expected to observe the wounds daily.</p> <p>Interview on 6/3/15 at 1:20 p.m. with the director of nursing revealed: *Her expectation had been that staff should have contacted the physician for changes in treatment if the wounds were not healing. *The nurses had not been observing the resident's wounds daily. *The provider should have had the resident seen by the E-Long Term Care specialist. *The provider's policy had not been followed.</p> <p>The ADON and DON attempted contact by phone with the physician twice during the time of the survey. The physician had not returned those calls at that time.</p> <p>Review of the provider's revised July 2014 Pressure Ulcer Prevention and Wound Treatment policy revealed: *"When parts of the body are pressed against the bed, chair, each other or any object for a long period of time, the tissue may not get enough oxygen. If the pressure is unrelieved, the tissue can be damaged and a pressure ulcer can form."</p>	F 314		

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F 314	Continued From page 5 *Any wound showing no sign of healing by the fourth week or any evidence of wound deterioration at any point in time was to have been reviewed by the physician. *A notation was to have been made in the progress notes regarding any new treatment orders or an explanation why the same treatment was being continued.	F 314	F 323 A The corrective action includes implementation of a written procedure for dining room assistance that specifically mentions monitoring of residents with swallowing difficulties who are determined to be at risk for aspiration such as resident 1. * Resident 1's care plan was reviewed and revised to address his Choking risk. SA/SOPH/JJ	7/2/15
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 A. Based on observation, interview, record review, and policy review, the provider failed to provide properly supervise one of one sampled resident (1) who was at risk for choking or aspiration (inhale food into the lungs). Findings include: 1a. Observation on 6/1/15 at 5:00 p.m. and at 5:10 p.m. on the third floor revealed: *Resident 1 was sitting at a table in the third floor dining room. In front of him was a divided plate with food. He had been feeding himself with a curved handled spoon. *There were two nursing assistants and one medication aide by the nurses station.	F 323	A directed in-service reviewing the procedure for dining assistance for facility staff who monitor residents in dining rooms, will be conducted. Compliance with following this procedure will be monitored by nurses or Medication Aides delegated to complete a monitoring tool designed to observe for staff compliance with the dining room assistance procedure. Two ← * monitoring tools will be completed by the nurses or Medication Aides * weekly SA/SOPH/JJ or more often as needed and reviewed by the DON. The DON will report the results of these monitoring tools to the QIC in August, 2015. This will be continued quarterly until the QIC advises to discontinue.	* SA/SOPH/JJ

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F 323	<p>Continued From page 6</p> <p>*The dining room was not in view of the nurses station.</p> <p>*During the above time a staff member had not been present in the dining room.</p> <p>Interview on 6/1/15 at 5:30 p.m. on the first floor with registered nurse (RN) M revealed:</p> <p>*She was working on the first and third floors that day.</p> <p>*The nurses usually worked one floor, but she had to watch first and third floor today.</p> <p>*She had been monitoring first floor meal service.</p> <p>*The third floor nurse usually monitored the third floor dining room during mealtime.</p> <p>*She had been covering both floors and had been unable to monitor the third floor dining room.</p> <p>Surveyor: 35625</p> <p>b. Observation on 6/2/15 from 8:15 a.m. through 8:40 a.m. in the third floor dining room revealed:</p> <p>*Resident 1 had been sitting at a table. In front of him was a divided plate with food and a foam handled spoon.</p> <p>*There was one RN and two certified nursing assistants (CNA) on the third floor at that time.</p> <p>*A staff member had not remained in the dining room during that time.</p> <p>Observation on 6/2/15 from 12:00 noon through 12:30 p.m. revealed:</p> <p>*Resident 1 and another resident had been eating in the third floor dining room.</p> <p>*A staff member remained in the dining room during that time.</p> <p>Review of resident 1's medical record revealed:</p> <p>*A history of dysphagia (trouble swallowing) following a stroke.</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>*He was on a constant carbohydrate and mechanically soft (easy to chew) diet. *He used a divided plate and foam-handled silverware for independent eating.</p> <p>The Minimum Data Set (MDS) assessment dated 9/18/14 and 3/18/15 revealed: *He required supervision and set-up assistance with meals. *Coughing/choking with regard to swallowing had been marked on the MDS. *He received a therapeutic and mechanically altered diet. *He was able to respond to questions with yes or no answers.</p> <p>The 3/25/15 care plan for resident 1 revealed he: *Had been at a risk for aspiration. *Had chosen not to follow a pureed diet (no chewing needed) recommendation. *Needed reminders to slow down his pace of eating/drinking to avoid choking. *The CNA care plan had not addressed his risk of choking/aspiration.</p> <p>The speech therapist's (ST) note from 1/13/15 at 12:09 p.m. regarding resident 1 revealed: *He had an episode of coughing and choking at breakfast on 1/12/15. *He had wished to eat a diet and consistency of his choice. *His aspiration risk remained significant.</p> <p>Interview on 6/2/15 at 5:30 p.m. with RN F regarding resident 1 revealed: *Residents in the third floor dining room were to be supervised by a licensed nurse or CNA. *Resident 1 had been in the third floor dining room due to previous disruptive behaviors.</p>	F 323		

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F 323	Continued From page 8 Interview on 6/3/15 at 9:55 a.m. with the director of nursing (DON) regarding resident 1 revealed: *Her expectation was for the staff to observe residents in the third floor dining room during meal time. *Observation and supervision was provided by a licensed nurse, CNA, activity staff, or dietary staff. *The licensed nurses and CNAs were encouraged to have daily report together. *Updates and concerns regarding residents would be presented at that time. *She felt the joint report was not happening on a consistent basis. Policies concerning the supervision and assistance of residents in the dining room was requested. None were received before the end of the survey. Surveyor: 16385 B. Based on observation, measurement, interview, and policy review, the provider failed to ensure side rails had been assessed for safety and entrapment (getting caught in) risk for 12 of 12 random observations of beds located throughout the facility. Findings include: 1. Observations on 6/2/15 from 8:30 a.m. through 9:15 a.m. and again on 6/3/15 from 7:30 a.m. through 8:00 a.m. revealed twelve beds with metal side rails. The silver side rails had two bars between each end. The measurements between the bars were 8 1/2 inches in width and 10 1/2 inches in height. The tan side rails had two bars between each end with measurements between the bars of 7 1/2 inches in width and 7 1/2 inches in height for the center gap. The two end gaps	F 323	F 323 B The corrective action includes review and revision of Policy 6312.50 Safety by the DON, the medical director, and the interdisciplinary team. A directed in-service reviewing this revised policy will be conducted for nurses, CNAs, nurse aides, resident assistants, and plant operations staff. All side rails not in compliance with regulations were removed or secured down so they could not be used. This was completed June 4, 2015. Compliance with following this policy will be monitored by plant operations personnel delegated to complete a monitoring tool designed to observe for facility compliance with the use of regulation compliant side rails. _____ monitoring tool will be completed by plant operations personnel, _____ and reviewed by the Director of Plant Operations. The Director of Plant Operations or designee will report the results of these monitoring tools to the QIC in August, 2015. This will be continued quarterly until the QIC advises to discontinue.	* [Redacted] SB/SADPH/JJ * [Redacted] SB/SADPH/JJ * [Redacted] SB/SADPH/JJ

7/2/15
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F 323	<p>Continued From page 9</p> <p>measured 9 inches in width and 7 1/2 inches in height. Those gaps were large enough for a resident's head or other body part to get entrapped.</p> <p>Interview on 6/3/15 at 1:00 p.m. with the quality analyst and Minimum Data Set (MDS) assessment nurse revealed: *They were unaware the gaps in the metal side rails were too large and were a safety concern. *For safety purposes the gaps should have been no larger than 4 3/4 inches.</p> <p>Review of the provider's revised March 2015 Safety policy revealed: *No measurement requirements for the gaps in metal side rails. **"Mattresses assessed so gap is no more than 4 3/4" (inches)."</p> <p>Surveyor: 32332</p> <p>C. Based on observation, interview, and record review, and policy review, the provider failed to store cleaning and sanitizing chemicals securely for one of one beauty shop. Findings include:</p> <p>1. Random observations on 6/2/15 and on 6/3/15 between the hours of 8:00 a.m. through 9:00 a.m. of the beauty shop revealed: *It was located on the first floor of the building across from the elevator. *The main dining room was down the hall. *All residents who ate in the main dining room would have passed by the beauty shop door on their way to or from their rooms. *The dining room was a separate room. Residents entered through a doorway. *The door of the beauty shop was open.</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>*The room was unattended.</p> <p>*On the counter were two containers with the following liquids labeled: -Barbasol (for sanitizing hair clippers and equipment). Review of the product information revealed, "Keep out of reach of children. Danger." If swallowed, a poison control center was to have been called for treatment. -Brush Delite (used to dissolve hair from brushes or combs). Review of the product information revealed it was severely irritating and could cause corrosion/burns to the eyes (might cause blindness), skin, and lungs.</p> <p>Interview on 6/3/15 at 10:30 a.m. with beautician/dietary assistant N revealed: *She opened the beauty shop door at 8:00 a.m. *She did not begin seeing residents in the beauty shop until 9:00 a.m. *She assisted with breakfast in the dining room until 9:00 a.m. *She was aware those liquids were dangerous. *She used to place those containers in a cabinet. *She was told during last years survey she should have kept the containers on the counter. *She was not sure why she was supposed to have left them out. *She kept an eye on the beauty shop door as she assisted with meals down the hall.</p> <p>Interview on 6/3/15 at 1:20 p.m. with the director of nursing revealed: *She was not aware the chemicals had been unattended. *The chemicals should have been locked up securely away from the residents.</p> <p>Review of the provider's March 2014 Safety policy revealed, "Chemicals are not left where a patient</p>	F 323	<p>F 323 C</p> <p>The corrective action includes review and revision of Policy 7600.01 Beauty Area by the DON, the medical director, and the interdisciplinary team.</p> <p>A directed in-service reviewing this revised policy will be conducted for beauty shop personnel, nurses, nurse aides, CNAs, and Resident Assistants.</p> <p>The beauty area chemicals are kept secured. When room is unoccupied and staff is not present the entrance door will be kept shut. The door is locked after hours. This practice went into effect starting June 10, 2015.</p> <p>Compliance with following this policy will be monitored by a nurse or CNA delegated to complete a monitoring tool designed to observe for compliance with this policy. monitoring tool will be completed by a nurse or CNA and reviewed by the Activities Coordinator. The Activities Coordinator will report the results of these monitoring tools to the QIC in August, 2015. This will be continued quarterly until the QIC advises to discontinue.</p>	<p>* [Redacted] SB/5000H/JJ</p>

on 7/2/15 by the DON and A.DON SB/5000H/JJ in a locked cupboard SB/5000H/JJ

one weekly SB/5000H/JJ

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501		
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F 323	Continued From page 11	F 323			
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431			

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F 431	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, policy review, and manufacturer's guideline review, the provider failed to:</p> <ul style="list-style-type: none"> *Ensure limited access by unauthorized staff to three of three medication rooms. *Ensure nursing staff were signing the controlled substances count sheet in one of three medication rooms (second floor) after removal of medication from the blister pack (holds individual doses for administration). *Ensure medications that had been removed from the blister packs were appropriately wasted and not re-sealed back into seven of seven medication blister packs. *Ensure open dates and used by dates were written on the medication container that required dating after initial use for two of two inhaled medications. <p>Findings include:</p> <p>1a. Observation and interview on 6/2/15 at 10:50 a.m. with LPN O regarding the first floor medication cart revealed: *Two Advair (inhaled medication) discus inhalers had no "used by" dates written on it. *One of the Advair discus inhalers had no "opened on" date. *LPN O was unaware the medications required those dates as it expired one month after opening.</p> <p>Review of the patient pamphlet included in the packaging of the Advair discus inhaler revealed: **"Write the date you opened the foil pouch in the first blank line on the label." **"Write the "use by" date in the second blank line</p>	F 431	<p>F 431</p> <p>The corrective action includes review and revision of Policy 6312.77 Medication Administration & review of Policy 6312.72 Controlled Substance Administration, Control, & Accountability by the DON, the medical director, and the interdisciplinary team.</p> <p>A directed in-service reviewing these two policies will be conducted for nurses and Medication Aides ^{on 7/2/15} by the DON and A DON. <i>SB/SDPH/JJ</i></p> <p>1a. Advair discus inhalers were dated with an open date and expiration date on June 2, 2015. Education on dating inhalers will be provided to nurses and Medication Aides ^{on 7/2/15} by the DON and A DON. <i>SB/SDPH/JJ</i></p> <p>1b. Education on proper wasting of medications not administered will be provided to nurses and Medication Aides ^{on 7/2/15} by the DON and A DON. <i>SB/SDPH/JJ</i></p> <p>2. Policy 6312.77 now prohibits the storage of physician prescription pads at Maryhouse. Those prescription pads were removed and put into a bin to be shredded on June 3, 2015.</p>	<p>* [Redacted] 7/18/15 <i>SB/SDPH/JJ</i></p> <p>* [Redacted] <i>SB/SDPH/JJ</i></p> <p>* [Redacted] <i>SB/SDPH/JJ</i></p> <p>* [Redacted] <i>SB/SDPH/JJ</i></p> <p>* [Redacted] <i>SB/SDPH/JJ</i></p>

by the DON
SB/SDPH/JJ

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F 431	<p>Continued From page 13 on the label. That date is 1 month after the date you wrote in the first line."</p> <p>Interview on 6/3/15 at 8:15 a.m. with the director of nursing (DON) regarding the labeling of the Advair discus medication revealed it was her expectation manufacturer's instructions were to be followed.</p> <p>b. On 6/2/15 at 10:50 a.m. on the first floor there had been three narcotic controlled medications (hydrocodone and oxycontin; both used for pain relief) located in the medication cart that had been re-sealed.</p> <p>*Of those three narcotic controlled medications: -Two had been found re-taped inside the blister pack. -The other had also been re-taped but was missing and had been signed off as administered. *LPN O thought someone had punched out the wrong date of individual medication, had placed it back into the blister pack, re-sealed it with tape, and administered it later on the correct date. *She was unaware of what the provider's policy was with regard to proper wasting of medication if not administered.</p> <p>2. Observation and interview on 6/2/15 at 10:10 a.m. with registered nurse (RN) B and medication aide D in the second floor medication room revealed: *Five blister packs containing narcotic controlled medications: -Were laying on the counter. -Had been placed there as they were missing signatures on the controlled substance inventory (CSI) form attached to the blister pack. -The nurses who had administered the medications had forgotten to sign the CSI form.</p>	F 431	<p>Controlled substances left on the counter were placed into the locked box awaiting destruction on June 2, 2015. Nurses and Medication Aides will be educated on the importance of promptly signing off controlled substances and placing unused doses of controlled substances promptly into the locked box for destruction, * by the DON and ADON on 7/2/15. SB/SOOTH/JJ</p> <p>The medication room doors will have a unique key lock for each floor by July [redacted] * 18, 2015. SB/SOOTH/JJ</p> <p>Compliance with dating medications such as inhalers with both an open date and expiration date, proper wasting of medications not administered, signing off of controlled substances properly, and properly disposing of controlled substances to be destroyed will be monitored by a nurse or Medication Aide delegated to completing a monitoring tool designed to observe for compliance with these policies.</p> <p>Eight monitoring tools will be completed by a nurse or Medication Aide monthly, or more often as needed, and reviewed by the DON. The DON will report the results of these monitoring tools to the QIC in August, 2015 and quarterly until the QIC advises to discontinue.</p>	* SB/SOOTH/JJ

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F 431	<p>Continued From page 14</p> <ul style="list-style-type: none"> -Had six narcotic medications remaining in the blister packs. *Ten blank physician prescription pads were placed on a shelf. *All medication room keys opened all three medication rooms in the facility. *Floor nursing staff and medication aides on duty in the facility had keys that opened all medication rooms. *Any staff administering medications and on duty at that time would have access to the second floor medication room. *They agreed: <ul style="list-style-type: none"> -Those controlled narcotic medications should not have been stored on the counter and should have been placed in the locked destruction box inside the medication room away from unauthorized access. -The prescription pads should not have been on the shelf and should have been secured from unauthorized access. <p>Interview on 6/3/15 at 8:15 a.m. with the DON regarding the second floor medication room revealed:</p> <ul style="list-style-type: none"> *She had been unaware physician prescription pads were in the facility. *The prescription pads should not have been left on the shelf. *The controlled narcotic medication that had been on the counter awaiting signatures of staff should have been placed in the locked box awaiting destruction. *She agreed: <ul style="list-style-type: none"> -All staff on duty that administered medications had access to that medication room, even if they were not working on the second floor. -The above controlled narcotic medications and prescription pads were at risk for diversion (theft), 	F 431			

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F 431	<p>Continued From page 15 as they were not secured from unauthorized staff.</p> <p>3. Observations and interviews on 6/2/15 from 10:00 a.m. through 5:30 p.m. and on 6/3/15 from 7:50 a.m. through 8:45 a.m. with RNs A and B, LPNs A and O, and medication aide C, regarding all of the medication carts (on all three floors) and the second floor medication room revealed:</p> <p>a. On 6/2/15 at 10:10 a.m. in the second floor medication room there was one blister pack with one remaining narcotic controlled medication (lorazepam; an anti-anxiety medication) that had been re-taped back into the packaging. *RN B was unsure why the medication had been taped back into the card, but thought someone maybe had attempted to administer it, was unable to, placed it back into the pack, and re-sealed it. *She was unaware of what the provider's policy was with regard to proper wasting of medication if not administered.</p> <p>b. On 6/2/15 at 4:25 p.m. on the second floor in the medication cart, three non- controlled medications (Tylenol) had been found taped back into the blister pack. *RN A was unsure why they had been re-sealed back into their blister pack. *She was a traveling nurse and had not re-sealed medication herself. *She was unsure what the provider's policy was related to blister packs and re-sealing medications.</p> <p>c. On 6/3/15 at 7:50 a.m. on the third floor in the medication cart there was one controlled narcotic medication blister pack found with morphine sulfate (a narcotic used for pain) re-sealed back into the blister pack. *Medication aide C explained although he had not re-sealed that medication with tape he had previously done so if a resident had refused their</p>	F 431			

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F 431	<p>Continued From page 16 medication.</p> <p>*He was unaware of what the provider's policy was in regards to proper wasting of medication if not administered.</p> <p>Interview on 6/3/15 at 8:15 a.m. with the DON regarding medications revealed: *She was unaware nurses and medication aides had been re-sealing some medications if they had been removed from their blister pack. *It had been her expectation staff would follow the provider's medication wasting policy and not re-seal medications back into the blister packs.</p> <p>Review of the provider's Controlled Substance Administration, Control, and Accountability policy revealed: **"Each dose of any controlled medication must be signed out on the CSI form at the time of administration." **"Opened but refused controlled substances are to be flushed in the toilet while witnessed by two staff. After destruction both staff sign the CSI and note dose wasted on the form."</p> <p>Review of the provider's 2/19/06 Medication Administration policy revealed: **"If a resident refuses a medication that was removed from the packaging, the licensed nurse will waste it." **"All medications administered will be given by or under the supervision of a licensed nurse, observing manufacturer's specifications."</p> <p>Per conversation with the DON there was no policy that addressed: *The physician prescription pads. *Limiting medication rooms to unauthorized staff.</p>	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
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NAME OF PROVIDER OR SUPPLIER avera maryhouse long term care	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/02/15. Avera Maryhouse Long Term Care (south resident wing - 1977 addition) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/04/15 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K050 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><i>Addendums noted with an asterisk per 7/10/15 telephone to facility Interim Director of operations. LF/SOD/H/JJ</i></p>	
K 044 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to maintain ninety minute horizontal exit doors in operating condition. The horizontal doors separating building 02 and building 01 on the third floor when closed provided a gap clearance between the door and</p>	K 044		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bob Suttler</i>	TITLE <i>Regional President</i>	(X6) DATE <i>6-25-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 26 2015
SD 57501

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K 044	Continued From page 1 the floor greater than 3/4 inch. Findings include: 1. Observation and testing at 1:30 p.m. on 6/02/15 revealed the cross-corridor horizontal exit doors separating building 02 and building 01 on the third floor when closed failed to maintain the ninety minute fire resistive rating of the assembly. The doors when closed provided a gap greater than 3/4 inch between the carpeted floor and the bottom of the door. NFPA 80 Article 3-6 indicates clearances should be no greater than 3/4 inch from the floor to the bottom of the door. Interview with the director of plant operations at the time of the observation confirmed that finding. He indicated the door had been adjusted but could not be lowered any further. Lowering the door further would cause it to catch on the floor when in the open position. If the door were to catch on the floor it could prevent the automatic self-closing mechanism from functioning.	K 044		
K 062 SS=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	K 062		

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K 062	<p>Continued From page 2</p> <p>provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition in randomly observed locations throughout the facility. Findings include:</p> <p>1. Observations beginning at 9:45 a.m. to 2:45 p.m. on 6/02/15 of the provider's automatic sprinkler system revealed multiple deficiencies with the maintenance of the sprinkler system as follows:</p> <p>*Concealed sprinkler head escutcheons covers missing throughout the building. Those covers were part of the sprinkler head assembly and should have been maintained as such.</p> <p>*A concealed sprinkler head cover that was being held in place by masking tape in the serving kitchen office. Masking tape was not an approved method for holding the covers in place. The tape would jeopardize the functionality of the fusible release device that would melt at a specific temperature during a fire situation.</p> <p>*Sprinkler heads with loading (lint and corrosion) in multiple locations.</p> <p>*The fire sprinkler main shutoff know as a PIV (post indicating valve) had rusted over the looking glass that would not enable the "open" or "close" indicator to be seen.</p> <p>*A rusted and bent dry pendant sprinkler head on the exterior of the building near the first floor stair enclosure exit by the nurses' station.</p> <p>Interview with the director of plant observations during the exit interview at 3:45 p.m. on 6/02/15 revealed he was unaware of the above conditions. He did not indicate why the preventative maintenance plan did not address those issues.</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> 1. Missing concealed sprinkler head escutcheons covers will be replaced. 2. A concealed sprinkler head cover held in place by masking tape in the kitchen serving office will be replaced. 3. Sprinkler heads with loading in multiple locations will be cleaned or replaced. 4. The post indication valve (PIV) will be cleaned or replaced. 5. A sprinkler head on the exterior of the building near the first floor stair enclosure exit by the nurses' station will be cleaned or replaced. <p>Annual preventative maintenance orders will be issued and tracked through the facility tracking system.</p> <p>* Director of Plant Operations or designee will report completion of these items to the quality assurance committee. LF/SODOH/JJ</p>	7/22/15

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NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/02/15. Avera Maryhouse Long Term Care (east patient wing - 1992 addition) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/04/15 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K050, K062, and K074 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 7/10/15 telephone to facility Interim Director of operations. LF/SD00H/JJ	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 32334	K 033		F

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

TITLE

(X6) DATE

Bob Suttler

Regional President

6-25-15

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501		
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K 033	Continued From page 1 Based on observation and review of previous survey records, the provider failed to maintain a protected path of egress. The east stair enclosure discharged past unprotected window openings. Findings include: 1. Observation at 9:30 a.m. on 6/02/15 revealed the exterior sidewalk and steps from the east exit stair enclosure discharged past unprotected window openings. Review of previous survey records at the time of the observation revealed that condition had previously existed. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety standards.	K 033			
K 044 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to maintain ninety minute horizontal exit doors in operating condition. The horizontal doors separating building 02 and building 01 on the third floor when closed provided a gap clearance between the door and the floor greater than 3/4 inch. Findings include: 1. Observation and testing at 1:30 p.m. on 6/02/15 revealed the cross-corridor horizontal exit	K 044		F	

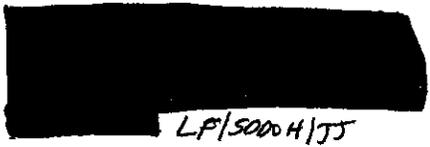
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K 044	<p>Continued From page 2</p> <p>doors separating building 02 and building 01 on the third floor when closed failed to maintain the ninety minute fire resistive rating of the assembly. The doors when closed provided a gap greater than 3/4 inch between the carpeted floor and the bottom of the door. NFPA 80 Article 3-6 indicates clearances should be no greater than 3/4 inch from the floor to the bottom of the door.</p> <p>Interview with the director of plant operations at the time of the observation confirmed that finding. He indicated the door had been adjusted but could not be lowered any further. Lowering the door further would cause it to catch on the floor when in the open position. If the door were to catch on the floor it could prevent the automatic self-closing mechanism from functioning.</p>	K 044		
K 050 SS=D	<p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p>	K 050		

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K 050	Continued From page 3 Based on observation and interview, the provider failed to ensure staff were familiar with fire procedure policy. Findings include: 1. Observation at 2:45 p.m. on 6/2/15 during the fire drill revealed the nurse responding to the simulated fire failed to implement the provider's fire procedure policy. The provider has adopted the R.A.C.E (Rescue, Alarm, Contain, Extinguish) fire procedure policy. Upon discovering the fire simulation place card in the resident's room, she left the resident's room to ask what to do. She then returned to remove the resident from the room and closed the door. The resident was moved to the corridor. The resident should have been moved to a safe location either in an adjoining smoke compartment or neighboring resident room. Miscommunication between the nurse that discovered the fire and the charge nurse resulted in a wrong room number when the code red fire alert was announced over facility's paging system. Communication of the location of the fire prior to activating the facility's alarm was critical due to the high volume of the alarm system making communication difficult. Interview with the staff at the time of the observation that responded to the fire drill confirmed that observation.	K 050	K050 *  LF/5000H/JJ * Education for facility staff will be provided annually through Avera Learning Center, in addition to the monthly fire drill conducted to evaluate staff performance. Fire safety education was provided to all staff in May 2015. After action reports of fire drills will be reported at the quality meeting or sooner as needed. LF/5000H/JJ	7/22/15
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	K 062		

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K 062	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition in randomly observed locations throughout the facility. Findings include:</p> <p>1. Observations beginning at 9:45 a.m. to 2:45 p.m. on 6/02/15 of the provider's automatic sprinkler system revealed multiple deficiencies with the maintenance of the sprinkler system as follows:</p> <ul style="list-style-type: none"> *Concealed sprinkler head escutcheons covers missing throughout the building. Those covers were part of the sprinkler head assembly and should have been maintained as such. *A concealed sprinkler head cover that was being held in place by masking tape in the serving kitchen office. Masking tape was not an approved method for holding the covers in place. The tape would jeopardize the functionality of the fusible release device that would melt at a specific temperature during a fire situation. *Sprinkler heads with loading (lint and corrosion) in multiple locations. *The fire sprinkler main shutoff know as a PIV (post indicating valve) had rusted over the looking glass that would not enable the "open" or "close" indicator to be seen. *A rusted and bent dry pendant sprinkler head on the exterior of the building near the first floor stair enclosure exit by the nurses' station. <p>Interview with the director of plant observations during the exit interview at 3:45 p.m. on 6/02/15 revealed he was unaware of the above conditions. He did not indicate why the preventative maintenance plan did not address</p>	K 062	<p>K062</p> <ol style="list-style-type: none"> 1. Missing concealed sprinkler head escutcheons covers will be replaced. 2. A concealed sprinkler head cover held in place by masking tape in the kitchen serving office will be replaced. 3. Sprinkler heads with loading in multiple locations will be cleaned or replaced. 4. The PIV will be cleaned or replaced. 5. A sprinkler head on the exterior of the building near the first floor stair enclosure exit by the nurses' station will be cleaned or replaced. <p>Annual preventative maintenance orders will be issued and tracked through the facility tracking system.</p> <p><i>* Director of plant operations or designee will report completion of these items to the quality assurance committee. LF/SD00H/JJ</i></p>	<i>7/22/15</i>

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K 062 K 074 SS=E	<p>Continued From page 5 those issues.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector, so the water discharge was not interrupted in two randomly observed residents' rooms (116 and 118). Findings include:</p> <p>1. Observation at 11:50 p.m. on 6/02/15 revealed double occupancy rooms with privacy curtains. Those privacy curtains did not conform to NFPA 13 (National Fire Protection Agency 13, Standard</p>	K 062 K 074	<p>K 074 NFPA compliant curtains will be installed ⁿ by environmental Services. Curtain checks will be added to the preventive maintenance schedule on a bi annual basis to be completed by plant operations.</p> <p><i>L F/5000H/JJ</i></p>	<i>7/22/15</i>

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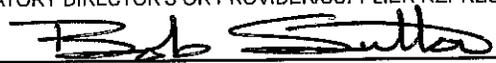
K 074	Continued From page 6 for the Installation of Sprinkler Systems). NFPA 13 requires privacy curtains to have the top 18 inches to be a mesh material that is equivalent to 70% open to allow for proper fire sprinkler discharge pattern to develop. The privacy curtains installed were of a solid fabric material from floor to ceiling. Interview with the director of plant operation during the exit interview at 3:45 p.m. on 6/02/15 confirmed that finding.	K 074		
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/02/15. Avera Maryhouse Long Term Care (building 03 common use area - original 1954 construction) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/04/15 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K038 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 7/10/15 telephone to facility Interim Director of operations. LF/5000H/JJ</p>	
K 011 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p>	K 011		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Regional President (X6) DATE 6-25-15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 011	Continued From page 1 Based on observation, testing, and interview, the provider failed to maintain the ninety minute fire resistive barrier rating of the common wall separating a non-conforming building, the unsprinkled hospital administration area in one location (hall to basement service tunnel). Findings include: 1. Observation at 1:45 p.m. on 6/02/15 revealed a hall leading to the basement of the hospital administration area. That hall had a ninety minute fire rated cross-corridor door at the two hour fire-rated wall separating the nursing home from the hospital. The door was held open with a magnetic hold open device. Testing of that door revealed the door would bind on the floor and not allow the door to close freely with the door's self-closing device. Also that door when forced over the area where the door was binding would not latch into the door frame. Exit interview with the plant operations manager at 3:00 p.m. on 6/02/15 revealed he was unaware of the non-functioning latching mechanism. He did not indicate if that door was on a preventative maintenance checklist to ensure it was checked on a regular basis for functionality.	K 011	K 011 This door was adjusted for proper operation. Fire door operations are part of NFPA preventative maintenance standards, in facility tracking system, to ensure it is checked on a regular basis for functionality. <i>* Director of plant operations or designee will report functionality of fire door operation to the quality assurance committee for two consecutive quarters. LF/SOPH/JJ</i>	6/3/15	
K 020 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by:	K 020		F	

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K 020	Continued From page 2 Surveyor: 32334 Based on observation and previous survey review, the provider failed to maintain the one hour fire resistive rating for three of three stair enclosures (north and east of the craft room and the southeast stairs). Findings include: 1. Observation during the survey on 6/02/15 revealed three stair enclosures with doors without a label identifying their fire resistive rating. Those doors were 1 3/4 inch hollow metal doors. The doors were located at the following locations: *To the stair enclosures north of the craft room on the first and second floors. *To the stair enclosures east of the craft room on the first and second floors. *To the southeast stair enclosures on first and second floors. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety standards.	K 020			
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022			

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K 022	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to furnish three exit signs in the chapel to ensure the path of egress to exits were identified. Findings include: 1. Observation at 9:35 a.m. revealed an interior chapel space with three exit access doors that exited back into the facility's corridor system. The occupant load for that space was over thirty persons and path of egress travel was not obvious and would therefore require exit access doors to be marked. Exit access doors from that chapel space did not have exit signs. Five other doors to storage, staging and equipment rooms could also be mistaken for exit access doors. Interview with the director of plant operations at the time of the observation revealed he was unaware of that condition and confirmed that requirement.	K 022	K 022 Exit signs will be installed in the Chapel by vendor to meet NFPA 101 Standards. <i>* Director of plant operations or designee will report completion of this item to the quality assurance committee. LP/5000#/JJ</i>	<i>7/22/15</i>
K 044 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the ninety minute horizontal exit at one randomly observed location (unsealed wall penetrations on the first floor above the elevator equipment room door). Findings include:	K 044	K 044 This wall will be sealed by installing fire rated caulk.	<i>7/22/15</i>

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NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501	
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K 044	Continued From page 4 1. Observation at 11:25 a.m. on 6/02/15 revealed a three hour fire rated wall separating building 02 from building 03. Further observation revealed unsealed penetrations through that wall for communication cable above the lay in acoustical ceiling tile. The unsealed penetrations were located above the door into the elevator equipment room. Those penetrations should have been sealed with an approved fire resistive rated material or caulking. Interview with the director of plant operations at the time of the observation confirmed that condition.	K 044	<i>*This will be completed by plant operations. Review of fire rated walls will be added to preventive maintenance on a quarterly schedule. Director of plant operations or designee will report completion of this item to the quality assurance committee. LF/SDDoH/TJ</i>	
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 in randomly observed locations throughout the facility. Findings include: 1. Observations beginning at 9:45 a.m. to 2:45 p.m. on 6/02/15 of the provider's automatic sprinkler system revealed multiple deficiencies with the maintenance of the sprinkler system as follows: *Concealed sprinkler head escutcheons covers missing throughout the building. Those covers	K 062	K 062 1. Missing concealed sprinkler head escutcheons covers will be replaced. 2. A concealed sprinkler head cover held in place by masking tape in the kitchen serving office will be replaced by. 3. Sprinkler heads with loading in multiple locations will be cleaned or replaced. 4. The PIV will be cleaned or replaced. 5. A sprinkler head on the exterior of the building near the first floor stair enclosure exit by the nurses' station will be cleaned or replaced. Annual preventative maintenance orders will be issued and tracked through the facility tracking system.	<i>7/22/15</i>

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

PRINTED: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER avera maryhouse long term care			STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501		
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K 062	Continued From page 5 were part of the sprinkler head assembly and should have been maintained as such. *A concealed sprinkler head cover that was being held in place by masking tape in the serving kitchen office. Masking tape was not an approved method for holding the covers in place. The tape would jeopardize the functionality of the fusible release device that would melt at a specific temperature during a fire situation. *Sprinkler heads with loading (lint and corrosion) in multiple locations. *The fire sprinkler main shutoff know as a PIV (post indicating valve) had rusted over the looking glass that would not enable the "open" or "close" indicator to be seen. *A rusted and bent dry pendant sprinkler head on the exterior of the building near the first floor stair enclosure exit by the nurses' station. Interview with the director of plant observations during the exit interview at 3:45 p.m. on 6/02/15 revealed he was unaware of the above conditions. He did not indicate why the preventative maintenance plan did not address those issues.	K 062	* Director of plant operations or designee will report completion of these items to the quality assurance committee. LF/SDPH/JJ		

ORIGINAL

PRINTED: 06/17/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10662	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 717 E DAKOTA PIERRE, SD 57501
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S 000	Initial Comments Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/1/15 through 6/3/15. Avera Maryhouse was found not in compliance with the following requirements: S210 and S301.	S 000	Addendums noted with an asterisk per 7/13/15 telephone to facility Interim Director of Operations and DON. SB/S000H/JJ	
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 29354 Based on employee file review, interview, and policy review, the provider failed to ensure five of five newly hired sampled employees (H, I, J, K, and L) were evaluated by a health professional to determine they were free from a reportable	S 210		

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



TITLE

Regional President

(X6) DATE

6-25-15

STATE FORM

6899

MHUP11

If continuation sheet 1 of 4

JUN 25 2015

SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10662	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER avera maryhouse long term care	STREET ADDRESS, CITY, STATE, ZIP CODE 717 E DAKOTA PIERRE, SD 57501
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S 210	<p>Continued From page 1</p> <p>communicable disease. Findings include:</p> <p>1. Review of employees H, I, J, K, and L's employee files revealed: *They had all become employed by the provider since February 2015. *They had not been evaluated by a health professional to determine they were free from a reportable communicable disease.</p> <p>Interview on 6/2/15 at 4:30 p.m. with the infection control/employee health registered nurse (RN) revealed: *The physical ability assessment informed consent form for employees H, I, J, K, and L had been signed by an occupational therapist (OT) or a physical therapist (PT). *She had been given the forms after the OT or PT had signed the forms. *She had not signed the forms.</p> <p>Interview on 6/3/15 at 7:45 a.m. with the director of nursing and the quality analyst RN confirmed employees H, I, J, K, and L: *Had not been evaluated by a health professional to determine they were free from a reportable communicable disease. *The physical ability assessment informed consent forms had been signed by the OT, PT, or physical therapy assistant.</p> <p>Review of the provider's November 2014 Pre-Employment Health policy revealed the purpose was "To provide a consistent policy for compliance with [name of facility] Employee Health policies and State Health Department requirements for immunizations."</p>	S 210	<p>S 210 All new employees will be evaluated by a licensed health professional for freedom from reportable communicable disease. <i>SB/5000H/JJ</i></p> <p>* All present employee files, including employees H, I, J, K, and L, will be reviewed and evaluated as necessary by a licensed health professional for freedom from communicable disease. The employee health nurse will review all new and current long-term care employee evaluations monthly and will report the results of the monitoring tools to the Quality Improvement Committee (QIC) in August 2015. This will be continued quarterly until QIC advises to discontinue. <i>SB/5000H/JJ</i></p>	<p>*  7/22/15 <i>SB/5000H/JJ</i></p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10662	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER
AVERA MARYHOUSE LONG TERM CARE

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

(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 301	Continued From page 2	S 301		
S 301	<p>44:04:07:16 Required dietary in-service training</p> <p>The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to provide eight of nine required annual in-service training sessions (food safety, food handling and prep techniques, food-borne illness, serving and distribution procedures, leftover food handling policy, time and temperature controls for food prep and service, nutrition and hydration, and sanitation requirements) for all food handling staff. Findings include:</p> <p>1. Record review provided by the director of nutrition and food services of the dietary in-services from October 2014 to May 2015 revealed a record of staff meeting minutes, but none of the above required in-services except for the one about handwashing.</p> <p>Interview on 6/3/15 at 9:10 a.m. with staff E revealed: *She was the day cook in the serving kitchen in</p>	S 301	<p>S 301 Dietary and food handling staff will receive all mandatory in service training [redacted] through on-line education by 7/18/15. The present policy and procedure for mandatory training in food safety, food handling and prep techniques, food-borne illness, serving and distribution procedures, leftover food handling, time and temperature controls for food prep and service, nutrition and hydration, and sanitation requirements for all food handling staff will be reviewed and revised as necessary by the director of food service. The director of food service will be monitoring for compliance of the mandatory education provided to all new and annual staff education monthly, and will be reporting the results of the monitoring tools to the Quality Improvement Committee (QIC) in August 2015. This will be continued quarterly until QIC advises to discontinue. SB/SOASH/JJ</p>	<p>* [redacted] 7/18/15 SB/SOASH/JJ</p>

South Dakota Department of Health

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S 301	<p>Continued From page 3</p> <p>the nursing home. *She didn't think they (the dietary staff) had had the required in-services this past year. She remembered having had them previously.</p> <p>Review of the provider's policy for dietary in-services revealed there was no policy. I was given a March 2014 Employee Safety Procedure for Food and Nutrition Services. This surveyor asked for and did not receive any other policy.</p> <p>Interviews on 6/3/15 at various times from 8:30 a.m. to 12:45 p.m. with the director of nursing and the person in charge of daily activities revealed: *The director of nutrition and food services was not available today. *The dietary staff person in charge was to talk to me and provide more records but did not.</p>	S 301		