

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

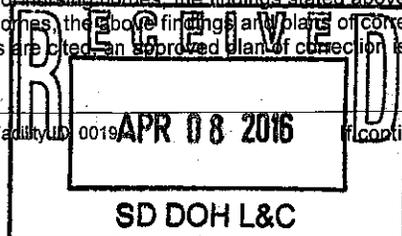
ORIGINAL

PRINTED: 03/24/2016
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 C 03/16/2016
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 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 3/14/16 through 3/16/16. Avera Maryhouse Long Term Care was found not in compliance with the following requirement(s): F356, F371, F441, and F514. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/14/16 through 3/16/16. Areas surveyed included quality of care/treatment for abuse/neglect. Avera Maryhouse Long Term Care was found in compliance.	F 000	*Addendums noted with an asterisk per email per 4/20/16 with facility administrator. JH/SDDOHH/EL	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	The facility does ensure the 24 hour nursing staff information is completed and posted daily. All residents are at risk. *Developed a procedure for daily staff posting requirements. JH/SDDOHH/EL Director of Nursing (DON) educated the [redacted] on the daily nurse staffing posting regulation requirements. The in-service education was completed on 3/16/16. The DON or designee will perform 2 audits weekly X 4, then monthly X 3 to ensure that the nurse staffing information is posted daily. Results of the audits will be reported by the DON and discussed at the quarterly Quality Assurance and Process Improvement (QAPI) for further review and recommendations and/or continuation/discontinuation of audits.	5/5/16 * business office assistant JH/SDDOHH/EL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danni Basler TITLE: Administrator (X6) DATE: 4/8/16

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 356	<p>Continued From page 1</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation and interview, the provider failed to ensure the twenty-four hour nursing staff information was completed and posted daily. Findings include:</p> <p>1. Random observation from 3/14/16 at 5:00 p.m. through 2:30 p.m. on 3/15/16 revealed no twenty-four hour nursing staff information available on all three floors for the residents or visitors to review.</p> <p>Interview on 3/15/16 at 2:30 p.m. with the business office manager revealed: *She had been responsible for completing and posting the twenty-four hour nursing staff information. *There was a clipboard hanging by the business office window. That clipboard should have had the nursing staffing information attached to it. *There had been no nursing staff information attached to the clipboard during any of the above observations. *She had not been consistently posting the</p>	F 356		

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F 356	Continued From page 2 nursing staff information daily for the past nine months. *She had: -Worked Monday through Friday. -Started her day at 8:00 a.m. -Not been aware of who was responsible for posting the nursing staff information on the weekends. Review of the provider's nursing staff sheets from 6/1/15 through 3/15/16 revealed June 2015 had been the only month any daily nursing staff sheets had been completed. There had been no nursing staff sheets to review from 7/1/15 through 3/15/16. Interview on 3/15/16 at 5:30 p.m. with the administrator regarding the twenty-four hour nursing staff information revealed she had been aware the: *Nursing staff information should have been posted daily and updated with any staff changes through-out the day. *Business office manager should have been completing and posting of the nursing staff information daily. *Nursing staff information had not been completed and posted daily. The provider had no policy or procedure in place for the staff to follow for completing and posting of the twenty-four hour nursing staff information.	F 356			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371			

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F 371	Continued From page 3 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, and policy review, the provider failed to ensure food was handled in a sanitary manner by four randomly observed dietary staff (G, H, I, and J) for two of two meal observations. Findings include: 1. Observation on 3/14/16 from 5:00 p.m. through 5:30 p.m. in the serving kitchen revealed: *Dietary aide G with the same pair of gloves on her hands: -Touched refrigerator door handles, silverware, microwave, and dishes. -Touched ready-to-eat food (bread, sandwich meat, and cheese). -Opened packages of bread, mayonnaise, peanut butter, jelly, and cans of soups. -Tossed used packages in the trash container. -Washed her gloved hands because "peanut butter on them." -Adjusted her clothing and glasses. -Dropped and broke a plate on the floor, cleaned pieces of plate from floor, and tossed them in the trash. -Continued to handle ready-to-eat foods. *Dietary aide J with the same pair of gloves on his hands: -Touched ready-to-eat food (bread, sandwich meat, and cheese).	F 371	F371 The facility does ensure food is handled in a sanitary manner. All residents are potentially at risk. The Food & Nutrition Services Director (FNS) and Registered Dietician (RD) will in-service all Food and Nutrition Maryhouse employees in regards to the policy and procedure for appropriate hand hygiene, hand washing and glove use during meal preparation and serving. The in-service/education will be completed by 4/13/16. The FNS director or designee will perform 2 ⁴ audits weekly X 4, then weekly ^{*weekly} X 3 to ensure that food is handled ^{handled} in a sanitary manner in regards to appropriate hand hygiene, handwashing, and glove use. Results of the audits will be reported by the FNS Director and discussed at the quarterly QAPI for further review and recommendations and/or continuation/discontinuation of audits.	5/5/16

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F 371	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Opened packages of mayonnaise. -Touched the door knob when going in and out of serving kitchen area. -Helped clean up broken plate pieces. -Continued to handle ready-to-eat foods. <p>Observation on 3/15/16 from 12:12 p.m. through 12:30 p.m. in the serving kitchen revealed:</p> <ul style="list-style-type: none"> *Dietary aide H with the same pair of gloves on her hands: <ul style="list-style-type: none"> -Touched the refrigerator door handle, silverware, microwave, drawer handles, and dishes. -Touched ready-to-eat food (bread, sandwich meat, and cheese). -Opened packages of mayonnaise and cans of soup. -Continued to handle ready-to-eat foods. *Dietary aide I with the same pair of gloves on her hands: <ul style="list-style-type: none"> -Touched bread package, peanut butter, and jelly packets. -Placed bread in toaster and removed toast. -Completed making peanut butter and jelly toast. <p>Interview on 3/15/16 at 1:00 p.m. with the administrator and registered dietitian (RD) K revealed:</p> <ul style="list-style-type: none"> *Gloves should be changed when going from one task to another. *Gloved hands should not have been washed. *The same gloves worn continuously would not have been appropriate. <p>Review of the provider's February 2004 revised Handwashing policy revealed:</p> <ul style="list-style-type: none"> *Hand contact with food should be avoided as much as possible. *Plastic gloves and appropriate utensils were available for use. 	F 371		

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F441</p> <p>The facility does ensure sanitary conditions are maintained during personal cares, medication administrations, and wound dressing cares for residents # 1, 2, 11, & 17. Since all residents are at risk, sanitary conditions are maintained during all cares provided by facility staff.</p> <p>The DON or designee will in-service all Maryhouse Nursing staff on Hand Hygiene and Infection Control Policies. This will include appropriate hand hygiene, handwashing, and glove use during resident personal cares, medication administration, and wound care to ensure sanitary conditions are maintained. The in-service/education will be completed by 4/13/16.</p> <p>The DON or designee will perform 3 random audits weekly X 4, then weekly X 4 months to ensure that appropriate handwashing and glove use is performed during observation of personal cares, medication administration, and wound cares. Results of the audits will be reported by the DON and discussed at the quarterly QAPI for further review and recommendations and/or continuation/discontinuation of audits. <i>*including random audits of residents 1, 2, and 11. Resident 17 has deceased. 11/18/2016</i></p>	5/5/16

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F 441	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions had been maintained during:</p> <ul style="list-style-type: none"> *Personal care for one of two sampled residents (2). *One of two randomly observed residents (17) who received a nebulizer treatment (medication administered in the form of a mist and inhaled into the lungs). *One of two observed medication administrations through an alternative route for one of one sampled resident (11). *A wound dressing application for one of one sampled resident (1). <p>Findings include:</p> <p>1. Observation and interview on 3/15/16 at 8:55 a.m. with certified nursing assistant (CNA) E providing personal care for resident 2 revealed:</p> <ul style="list-style-type: none"> *She had missed two opportunities for hand washing during that time. *With her clean gloves on she had: <ul style="list-style-type: none"> -Turned on the water faucet, wet the cleansing wipe, and provided perineal (area between the thighs) care to the resident. -Turned the water faucet off and dried the resident's perineal area with a dry cleansing wipe. *She confirmed the above had been her usual practice when providing personal care for the residents. <p>Interview on 3/16/16 at 2:55 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *She would have expected CNA E to have: <ul style="list-style-type: none"> -Removed her gloves and sanitized her hands after each time she touched the water faucet 	F 441		

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F 441	<p>Continued From page 7 handle.</p> <ul style="list-style-type: none"> -Applied clean gloves prior to cleansing the resident's perineal area. *She agreed: <ul style="list-style-type: none"> -The above process had not been performed in a sanitary manner. -That process had created the potential for cross-contamination of bacteria to the resident. <p>2. Observation on 3/15/16 at 11:45 a.m. of licensed practical nurse (LPN) C after administering a nebulizer treatment to resident 17 revealed:</p> <ul style="list-style-type: none"> *Without the use of gloves she had: <ul style="list-style-type: none"> -Prepared to clean the medication holding chamber and removed the chamber from the mask. -Turned on the water by touching the faucet handles without using a barrier. -Rinsed out the medication holding chamber. -Turned off the water by touching the faucet handles without using a barrier. -Re-attached the medication holding chamber to the mask. *Sanitized her hands. <p>Interview on 3/16/15 at 2:57 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She would have expected LPN C to have: <ul style="list-style-type: none"> -Used gloves while cleaning the nebulizer medication holding chamber. -Used a paper towel or hand towel to turn the water faucet on and off. The water faucet handles would not have been considered a clean surface. *She agreed: <ul style="list-style-type: none"> -The above process had not been performed in a sanitary manner. -That process had created the potential for cross-contamination of bacteria to the resident. 	F 441		

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F 441	<p>Continued From page 8</p> <p>3. Observation on 3/16/16 at 7:50 a.m. with LPN F with resident 11 revealed: *She had prepared to administer medications through a tube inserted into the resident's stomach. *With clean gloves she had: -Turned on the water by touching the faucet handles without using a barrier. -Filled a cup with water. -Turned off the water by touching the faucet handles without using a barrier. *Without removing those soiled gloves and washing/sanitizing her hands she had administered: -The resident's medication through the tube inserted into his stomach. -Artificial tears (moisturizing eye medication) into both of his eyes.</p> <p>Interview on 3/16/16 at 11:20 a.m. with LPN F revealed: *That had been her usual practice when administering medications through the tube inserted into resident 11's stomach. *She had not been aware: -She had not used a barrier to separate her gloves from the soiled water faucet handles. -She should have removed her gloves, washed/sanitized her hands, and applied clean gloves prior to administering the resident's eye medication.</p> <p>Interview on 3/16/16 at 3:00 p.m. with the DON confirmed the above process had not been completed in a sanitary manner. She agreed that process had created the potential for cross-contamination of bacteria to the resident.</p>	F 441		

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F 441	<p>Continued From page 9</p> <p>Review of the provider's 7/1/05 Administering Medication Via Naso-Gastric or Gastrostomy Tube policy revealed no procedure in place for the nursing staff to follow for proper glove use and hand washing.</p> <p>The provider had no policy or procedure in place for the administration of eye medications.</p> <p>Surveyor: 35121</p> <p>4. Observation and interview on 3/15/16 at 4:14 p.m. with registered nurse (RN) L during a wound dressing application for resident 1 revealed she had:</p> <ul style="list-style-type: none"> *Used an alcohol wipe to clean her hands and applied gloves. *Cleaned the open wound on resident 1's lower left leg with wound cleanser and gauze. *Discarded the soiled gauze into the trash. *Removed gloves and discarded them into the trash. *Not washed her hands. *Applied another pair of gloves. *Applied clean wound dressing to the wound and covered area with elastic gauze. *Removed gloves and discarded them into the trash. *Not washed her hands. *Applied another pair of gloves. *Trimmed resident 1's toenails and assisted her with her socks, slippers, and pants. *Removed gloves and discarded them into the trash. *Used an alcohol wipe to clean her hands. *Washed her hands with soap and water. *Confirmed she did not wash her hands twice after removing gloves. 	F 441		

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F 441	<p>Continued From page 10</p> <p>Review of resident 1's medical record revealed she was on contact isolation precautions (gloves and gown were to have been worn to prevent direct contact).</p> <p>Interview on 3/16/16 at 9:05 a.m. with RN A (infection control nurse) regarding the dressing application by RN L confirmed: *She would have expected the nurse to wash her hands after each glove removal. *RN L did not follow their hand hygiene and infection control polices.</p> <p>Interview on 3/16/16 at 2:30 p.m. with the DON regarding the dressing application by RN L confirmed: *She would have expected the nurse to wash her hands after each glove removal. *RN L did not follow their hand hygiene and infection control policies.</p> <p>5. Review of the provider's revised August 2014 Hand Hygiene policy revealed "Hand hygiene is the single most important procedure for the control of infection."</p> <p>Review of the provider's revised October 2015 Infection Control policy revealed "Hands are to be washed immediately after gloves are removed."</p> <p>Review of the provider's revised July 2015 Transmission Based Precautions Isolation policy revealed: **"Additional precautions beyond Standard Precautions are needed to interrupt transmission between patients, personnel, and visitors." **"Perform hand hygiene before donning PPE (personal protective equipment [gloves and gown]) and when removing PPE."</p>	F 441		

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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		
(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 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to document: *A completion date for two of ten sampled residents (2 and 5) who had pharmacy recommendations. *A time frame for the nursing staff to follow for two of ten sampled residents (2 and 5) who had as needed (prn) physicians' orders. Findings include:</p> <p>1. Review of resident 2's undated gradual dose reduction psychopharmacological medications form revealed: *The resident had been taking Lexapro and Remeron (antidepressants). *The pharmacist had recommended a dose reduction for those medications. *The physician had declined the recommendation.</p>	F 514	<p>F514</p> <p>The facility does ensure that a completion date is used for pharmacy recommendations and ensures a time frame for nurses to follow is included for "as needed" physician orders. For residents #2 & 5 no correction can be completed for past pharmacy recommendation or physician orders. All future pharmacy recommendations will have complete dates and "as needed" physician orders will have time frames for nursing staff to follow.</p> <p>The DON in-serviced the facility Pharmacy Consultant in regards to the requirement to have complete dates on pharmacy recommendation letters to physicians on 3/16/16. The DON will in-service all facility licensed nurses in regards to ensuring complete "as needed" physician orders are obtained to include: medication, complete date, timeframe to administer, dosage, route, and physician signature. The in-service/education will be completed by 4/22/16. Facility standing orders will be revised to ensure they are complete for all residents by May 5, 2016.</p> <p>The DON or designee will perform 2 random audits weekly X 4, then monthly X 3 to ensure that pharmacy recommendation letters have a complete date and that "as needed" orders are complete to include a time frame and physician signature. Results of the audits will be reported by the DON and discussed at the quarterly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p>	5/5/16	

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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	
(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 514	<p>Continued From page 12</p> <p>*No date to support when the: -Pharmacist had completed those recommendation. -Physician had reviewed those recommendation.</p> <p>Review of resident 2's July 2015 drug review form revealed: *The resident had been on an prn medication for a rash. *The pharmacist had recommended the medication to be discontinued. *The physician had ordered the medication to be discontinued.</p> <p>*No date to support when: -In July the pharmacist had completed those recommendations. -The physician had ordered the medication to be discontinued.</p> <p>2. Review of resident 5's drug review forms revealed: *In November 2015 the: -Pharmacist had documented "She is taking Losartan and Diltiazem for high blood pressure. She is getting her blood pressure taken twice a week and it is running high. May consider increasing a dose or adding another medication?" -Physician had declined the pharmacist's recommendations.</p> <p>*In December 2015 the: -Pharmacist had made the same recommendations as in November. -Physician again declined the pharmacist's recommendations.</p> <p>*No date to support when in November 2015 and December 2015 the: -Pharmacist had made those recommendations. -Physician had reviewed and declined those recommendations.</p>	F 514		

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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		
(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 514	<p>Continued From page 13</p> <p>Interview on 3/15/16 at 9:50 a.m. with registered nurse (RN) A confirmed: *The above pharmacy recommendations had been incomplete. *There had been no dates to support when the: -Pharmacist had made those recommendations. -Physician had reviewed the pharmacist's recommendations.</p> <p>Interview on 3/16/16 at 2:45 p.m. with the director of nursing (DON) and administrator confirmed: *The above pharmacy recommendations had been incomplete. *There should have been dates to support when the: -Pharmacist had made the above recommendations for the physician to review. -Physician had reviewed the recommendations made by the pharmacist.</p> <p>3. Review of resident 2's 2/3/16 physician's orders revealed: *The physician had ordered the following medications: -"AKWA (artificial) tears one drop in each eye prn." -"Morphine (pain medication) 4 milligrams (mg) per policy, prn." -"Mylanta 5 milliliters (ml) per policy, prn." *No documentation to support a time frame interval on how often the nursing staff could have administered those medications.</p> <p>4. Review of resident 5's current Maryhouse/TCU [Transitional Care Unit] Standing Orders revealed: *For constipation the physician had ordered the following medications:</p>	F 514		

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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		
(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 514	<p>Continued From page 14</p> <p>"Milk of Magnesia 30 ml orally prn." "Dulcolax suppository prn rectally." "Phosphate or soap suds enema prn rectally." *No documentation to support a time frame interval on how often the nursing staff could have administered those medications.</p> <p>5. Interview on 3/15/16 at 10:00 a.m. with RN B confirmed the above physician's orders had been incomplete. Those orders should have supported a time frame for the nursing staff to follow for proper administration of the medications.</p> <p>Interview on 3/16/15 at 2:50 p.m. with the DON and the administrator confirmed there should have been time frames documented on the above physician's orders. Those time frames would have ensured the nursing staff had administered those medications appropriately.</p> <p>Review of the provider's February 2014 Diagnostic and Therapeutic Orders policy revealed: *Purpose: "To assure that physician orders are carried out in an accurate and timely manner." *No procedure for the nursing staff to follow to ensure a complete physician's order had been received.</p>	F 514			

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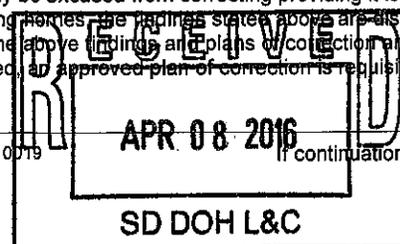
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/15/16. 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.	K 000		
K 044 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and document review, 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 3/15/16 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	K 044		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lanni Rode</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/8/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER avera 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 1 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. Review of the previous life safety code survey confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 044			

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/15/16. 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 3/15/16 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		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (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. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 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:	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dani Raske</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/8/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER avera 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
K 033	Continued From page 1 1. Observation at 11:30 a.m. on 3/15/16 revealed the exterior sidewalk and steps from the east exit stair enclosure discharged past unprotected window openings. Review of the previous life safety code survey confirmed that condition had existed since the original construction. The building meets FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000 in conjunction with the facility's commitment to continued compliance with the fire safety standards.	K 033		
K 044 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and document review, 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 11:30 a.m. on 3/15/16 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	K 044		F

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K 044	Continued From page 2 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. Review of the previous life safety code survey confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 044		

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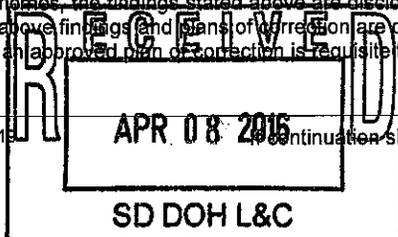
NAME OF PROVIDER OR SUPPLIER avera maryhouse long term care	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/15/16. 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. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/15/16 upon correction of the deficiencies 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 K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 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:	K 020		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamie Raske</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/8/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER AVERA 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
K 020	Continued From page 1 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. Review of the previous life safety code survey confirmed that condition had existed since the original construction. 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		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435034	MULTIPLE CONSTRUCTION A. BUILDING: 03 - BUILDING 03 B. WING _____	DATE SURVEY COMPLETE: 3/15/2016
NAME OF PROVIDER OR SUPPLIER AVERA MARYHOUSE LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 147

NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment shall be in accordance with National Electrical Code 9-1.2 (NFPA 99) 18.9.1, 19.9.1

This STANDARD is not met as evidenced by:

Surveyor: 18087

Based on observation and interview, the provider failed to maintain a 36 inch clear depth of working space for two of two electrical panels (therapy gym storage area). Findings include:

1. Observation at 10:30 a.m. on 3/15/16 revealed two portable cubicle partitions were on the floor in front of two electrical panels (labeled Panel C and Panel PC) in the therapy gym storage area. The partition panels obstructed access to the electrical panels. The floor was not marked to indicate the 36 inch clear space requirements for access to electrical panels. Interview with the director of plant operations confirmed that condition.

The deficiency affected one of numerous requirements for maintaining electrical equipment in one of two electrical panel locations.

K 147

The corrective action included yellow caution tape being put on the floor in the therapy gym storage area on 3/25/16 to ensure that nothing is placed in front of the electrical panel. A sign was put on each electrical panel to keep the area clear in front of the panel.

The Administrator will in-service all therapy staff in regards to the requirement to ensure a 36 inch clear depth is available in front of electrical panels. This education will be completed by 4/15/16.

The Director of Plant Operations or designee will perform 1 audit weekly X 4, then monthly X 3 to ensure electrical panels have available access.

Results of the audits will be reported by the Director of Plant Operations and discussed at the quarterly QAPI for further review and recommendations and/or continuation/discontinuation of audits.

5/5/16

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

The above isolated deficiencies pose no actual harm to the residents

ORIGINAL

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 03/16/2016
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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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(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	Compliance/Noncompliance Statement Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/14/16 through 3/16/16. Avera Maryhouse Long Term Care was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/14/16 through 3/16/16. Avera Maryhouse Long Term Care was found in compliance.	S 000		

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

TITLE

(X6) DATE

Jani Kaska

Administrator

4/8/16

STATE FORM

6899

9QNK11

Continuation sheet 1 of 1

