PRINTED: 01/29/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND INDED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		435070	B. WING	_		01/	24/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
AVEDA SI	STER JAMES CARE CEN	NTED		I -	111 WEST 11TH STREET			
AVERA SI	SIEK JAMES CAKE CEI	VIER .		Y	ANKTON, SD 57078			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		DATE	
TAG	NEGODATORY OR I	and the state of t			DEFICIENCY)			
F 000	INITIAL COMMENTS	;	F	000	Facility reviewed the current		0/45/0004	
					ADLBathing process. Identifie	ed	2/15/2024	
	A complaint health su	urvey for compliance with 42			residents bathing schedules w	vere	:	
		art B, requirements for Long			reviewed. All other residents			
		ras conducted from 1/23/24	4		bathing schedules were also			
		areas surveyed were			reviewed to ensure they were			
		nsistent regular resident			being followed according to fa	cility		
		James Care Center was			process. Identified resident's	,		
	found not in complian	ice with the following			occurrences were in Nov/Dec	/Jan		
	requirement: F676				therefore bathing for that time			
	<b>Activities Daily Living</b>		F	676	period could not be corrected.			
SS=E	CFR(s): 483.24(a)(1)	(b)(1)-(5)(i)-(iii)			Correction was limited to staff			
					education and ongoing bathin			
	§483.24(a) Based on				process. Facility has develop			
		dent and consistent with the			standardized bathing workshe			
		choices, the facility must			to use across all 5 neighborho	ods		
	, .	y care and services to			in order to monitor resident ba	aths		
		t's abilities in activities of			are being given on a weekly b	asis.		
		ninish unless circumstances ical condition demonstrate			Resident refusal will be			
		was unavoidable. This			documented in medical record	and		
	includes the facility e				noted on bathing worksheet.			
	moduces the samity of	mouning triat.			Inservice on bathing process	and		
	8483 24(a)(1) A resid	lent is given the appropriate			standardized bathing workshe			
	treatment and service	es to maintain or improve his			was conducted on February 1	st.		
		out the activities of daily			Monitoring and audits of bathi	ng		
	living, including those	specified in paragraph (b)			process will be done by RN			
	of this section				Houshold Coordinator's week	iy		
					times 4 weeks, then monthly t	imes		
	§483.24(b) Activities				3 months, then quarterly for 3			
		ride care and services in			quarters. RN Household			
		agraph (a) for the following			Coordinator's will report findin			
	activities of daily living	g:			Director of Nursing for compile			
	0400 04/b\/4\     !	a bathing dragging			results and submitting to QAP	1		
	§483.24(b)(1) Hygien				Committee for review and			
	grooming, and oral ca	are,			recommendation monthly for	3		
	8483 24/h)/2) Mahilih	y-transfer and ambulation,			months, then quarterly for 3			
	including walking,	y action and ambailding			quarters.			
	morading wanting,							
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	00	(X6) DATE	
	Anthony L Eri	ckson		Vic	ce President - Senior Services	02/	02/2024	

Any deficiency statement ending with an asterist (a) 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 protection is provided that these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID: 057W11

Facility ID: 0027

If continuation sheet Page 1 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  3		COMPLETED		
		435070	B. WING			01/24/2024	
NAME OF PROVIDER OR SUPPLIER  AVERA SISTER JAMES CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 676	Continued From page	e 1	F 67	76			
	snacks,  §483.24(b)(5) Commit (i) Speech, (ii) Language, (iii) Other functional of This REQUIREMENT by: Based on a complair observation, and interensure six of eight satisfied to the same six of eight satisfied in the same	eating, including meals and unication, including communication systems. is not met as evidenced at, record review, rview, the provider failed to impled residents (1, 2, 3, 4, d regular scheduled bathing.  Ith Dakota online report revealed: corted that on Sunday shift was short-staffed and bout the residents safety. It is concerned that the day thort-staffed and often etting their scheduled baths, going 8 or 9 days without a len short-staffed on and off diaddressed her concerns					
	nursing but stated no *At the time of the re thought any resident from being short-staff	oort, the complainant had not had a negative outcome fed.  atterview on 1/23/24 at 4:00					

ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
435070 B. WNG		C 01/24/2024			
433070	D. WING	_	REET ADDRESS CITY STATE ZIP CODE	01/	24/2024
NAME OF PROVIDER OR SUPPLIER  AVERA SISTER JAMES CARE CENTER			111 WEST 11TH STREET		
BE PRECEDED BY FULL	1	x			(X5) COMPLETION DATE
his care. not get a bath as often or 15 days. im not to get a bath have a bath at least ronic medical record gistered nurse (RN) evealed: following days:  personal care that he part of his weekly  or on 1/23/24 at 4:30 form revealed: fier. found her room. foundle of weeks since for red under her  and interview with G revealed: following days:	F	376			
	A35070  TOF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION)  To wheelchair at the his care. To the get a bath as often or 15 days. The immedial record gistered nurse (RN) evealed: Tollowing days:  To make the part of his weekly on 1/23/24 at 4:30 from revealed: To make the part of his weekly on 1/23/24 at 4:30 from revealed: To make the part of his weekly on 1/23/24 at 4:30 from revealed: To make the part of his weekly on 1/23/24 at 4:30 from revealed: To make the part of his weekly on 1/23/24 at 4:30 from revealed: To make the part of his weekly on 1/23/24 at 4:30 from revealed: The part of his weekly on 1	A BUILDI  435070  B. WING  T OF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION)  F of the care. Tot get a bath as often or 15 days. Im not to get a bath Thave a bath at least  Front medical record gistered nurse (RN) Evealed: Following days:  Personal care that he part of his weekly  F on 1/23/24 at 4:30 F on revealed: F on the care of the care	A BUILDING  435070  B. WING  TOF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION)  F 676  Town to get a bath as often or 15 days. im not to get a bath have a bath at least  conic medical record gistered nurse (RN) evealed: billowing days:  personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly  or on 1/23/24 at 4:30 com revealed: personal care that he part of his weekly	A BUILDING  435070  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  TAG  F 676  T 676  F 676  F 676  F 676  F 676  F 677  F 677	A BUILDING  B WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2111 WEST 11TH STREET  YANKTON, SD 57078  SE PRECEDED BY PULL  TITIFYING INFORMATION)  F 676  The preceded by Pull  Trifying information  F 676  Trifying information  F 676  Trifying information  Trifying information  F 676  Trifying information  Trifying information  F 676  Trifying information  Trifying informatio

	4/2024
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2111 WEST 11TH STREET  YANKTON, SD 57078	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
this date.  4. Interview on 1/24/24 at 7:49 a.m. with resident life coordinator E revealed:  "She had reviewed the staff schedule and stated that there was no bath aide scheduled today but that there was no bath aide scheduled today but that there would have been more staff coming in later in the morning to assist with bathing.  "She stated that they had been short-staffed the last two weeks and that had contributed to the residents not receiving regular bathing.  "She stated that staff do their best to ensure residents get their baths.  5. Interview on 1/24/24 at 7:55 a.m. with registered nurse (RN) clinical care coordinator G regarding resident bathing revealed:  "A bath schedule was printed every morning.  "They attempted to follow the bathing schedule.  "A bath aide was not schedule for today.  "Staff completed the resident's baths when there was no bath aide.  "She had done two resident baths that morning.  "The resident life coordinator would also do baths when available.  6. Interview on 1/24/24 at 8:00 a.m. with resident life coordinator H revealed:  "She normally would have had a busy schedule with scheduled activities for the residents.  "She was a certified nursing assistant (C.N.A.)  "The tot squeeze in baths between activities.  7. Interview on 1/24/24 at 8:10 a.m. with medication aide F revealed:  "The staff used a weekly bathing schedule sheet to determine which resident would need a bath.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ATION NILIMOED		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		435070	B. WNG	_		01/	24/2024
NAME OF PROVIDER OR SUPPLIER  AVERA SISTER JAMES CARE CENTER			•	2.	TREET ADDRESS, CITY, STATE, ZIP CODE 111 WEST 11TH STREET ANKTON, SD 57078		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	numbers listed with shighlighted with a number. When asked room numbers meant them, she stated that showers and the number of resident's last bath.  *When asked about the more than 10 days, short-staffed.  *She stated that she bed bath when composed bath when composed bathing needs and so huddle.  *The staff would ident gone the longest with those residents the phase would attempt the staff to work as the best more residents' baths she stated that staff due to the recent weathat were out on med as hed bath with their she had been utilizing to assist with resident mid-morning to see if would come in to assist would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would come in to assist with resident mid-morning to see if would in the mid-morning to see if	heet had the resident's room ome that had been inber beside the room I what those highlighted those were the priority inber by the room number days it had been since the interested it was due to being would give every resident a leting morning care.  24 at 8:30 a.m. with RN for D revealed: ald discuss the resident chedules during the morning tify those residents who had would a bath and would make riority for that day. To schedule the most efficient ath aide to attempt to get a completed during the day. Ing had been a challenge ather and a couple of staff lical leave. To complete the most efficient ath aide to attempt to get ather and a couple of staff lical leave. To couple of part-time staff they were needed and the ist with resident baths.  Interview on 1/24/24 at 8:45 in his room revealed:	F	676			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435070	B. WING			1	C <b>24/2024</b>
NAME OF PROVIDER OR SUPPLIER  AVERA SISTER JAMES CARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE  111 WEST 11TH STREET  ANKTON, SD 57078	1 011	2-1/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	*He stated that he had the stated he had go without a shower befinere did a good job them.  Review of resident 3' with RN clinical care the had received short 12/21/2301/04/2301/23/24. *His care plan reveal bathing every Tuesdathing every Tuesdathing every Tuesdathing every Tuesdathing every Tuesdathing every the stated they try to the	d a shower yesterday. The at least two weeks fore that, the staff that were there just was not enough of  SEMR and and interview coordinator G revealed: The swers on the following dates:  The sedhe would have received  The sy.	F	676			
	care coordinator K re revealed:  *They were behind o snowstorm and some *The bath assignmer schedule was in the value with a bath the neutral Review of the 1/2 Bath Schedule sheet *Resident 4 had not a *Resident 6 had not a *The state *The state of the	rse (LPN) J and RN clinical garding resident bathing in baths due to a recent experience residents with influenza. In this were printed and the whirlpool room. In this sed the goal was to follow ext day.  22/24 Dakota Neighborhood					

Facility ID: 0027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	A BOLDING		С			
		435070	B. WING _		01/2	4/2024
NAME OF PROVIDER OR SUPPLIER  AVERA SISTER JAMES CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page  12. Review of resident *The resident received dates: -12/21/23 -01/03/24 -01/06/24 -01/22/24 *The care plan indicates have received a whirth needed.  13. Review of resident *The resident had received automatical *The resident had r	sc identifying information)  e 6  It 4's EMR revealed: It baths on the following  Ited that the resident should pool bath weekly and as  It 5's EMR revealed: It is is EMR revealed: It is is even baths on the following	F 6	DEFICIENCY)	ATE	DATE
	15. Interview on 1/24/clinical care coordina *When asked about bresidents 4, 5, and 6, been receiving baths *Resident 6 would repreferred her baths ecould not always be a to work later in the me	athing frequency for she stated they should have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	TIPLE CONSTRUCTION  NG		COMPLETED			
		435070	B. WING_		(	1/24/2024		
NAME OF PROVIDER OR SUPPLIER  AVERA SISTER JAMES CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY)	HOULD BE COMPLETION			
F 676	of quality C revealed: *DNS B stated that the residents would have weekly. Some resided have received a bed include washing the reare (cleaning the priwith every resident at *She stated that she each neighborhood be were tracking resident *The unit care coordineighborhood would bathing was getting c *When asked what the currently to solve the director of quality C be attempting to hire stadifficult. *They do not currently bathing preferences and frequences.	revices (DNS) B and director  re expectation was that received a bath/shower rits with dementia would bath. Bed baths would resident's faces and peri vate areas) was completed bedtime.  would have liked to have re consistent with how they re baths/showers. recollaborate daily to ensure completed for each resident. re provider was doing resident was doing resident bath bath bath bath and reconsistent was doing resident bath bath bath and reconsistent was doing resident bath bath bath bath bath bath bath bat	F	6376				