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

PRINTED: 11/06/2023
FORM APPROVED
OMB NO. 0938-0391

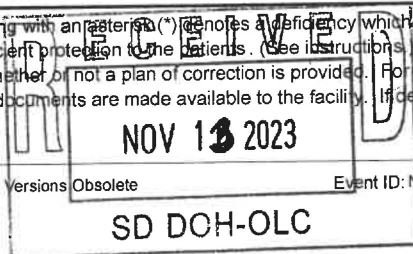
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. BUILDING ______ B. WING ______	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA ROSEBUD COUNTRY CARE CENTER	126 S LOGAN AVE GREGORY, SD 57533

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/24/23 through 10/26/23. Avera Rosebud Country Care Center was found not in compliance with the following requirement: F657.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	Starting today the facility will adopt a "Mobility Positioning and Safety device evaluation process". The Director of Nursing or their Designee will complete "Mobility Positioning, Safety device evaluation for residents 10,15,and 20 by Dec. 10, 2023. Thereafter all residents with devices will have their Mobility Positioning, Safety Device evaluation completed with every Comprehensive, Quarterly, and Significant Change MDS. In addition we will update and include the "Mobility positioning safety device evaluation" in our restraint policy. The Director of nursing or their Designee will audit completion of evaluations by Dec.10,2023 and audit completion of said evaluation for all residents with Comprehensive, Quarterly, and Significant Change weekly for one month, and then monthly thereafter until QA determines sustained compliance is met. Results will be reported to the administrator at the quarterly QA meetings.	10DEC23 AT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Timanus
TITLE: Administrator
(X6) DATE: 09Nov23

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 657	Continued From page 1 by: Based on observation, interview, record review, and policy review, the provider failed to implement Pull-Tab alarm assessments, reassessments of those alarm devices, update resident care plans to reflect the current use of those alarms, and notify the resident's family when the Pull-Tab Alarms were implemented for three of three sampled residents (10, 15, and 20). Findings include: 1. Observation and interview on 10/24/23 at 10:41 a.m. with resident 10 revealed: *He was lying in bed watching television. *A Pull-Tab alarm was attached to the bed and a garment clip was attached to his shirt. *He had a wheelchair and a walker in the corner of his room. *His feet were elevated, and he had heel protectors on both feet. *He stated that he had gone to the hospital after a fall for a broken hip, he had done some therapy afterwards and he had sores on his heels that were healing. Observation on 10/24/23 at 11:46 a.m. of resident 10 in the dining room during the lunch meal revealed: *The resident was sitting in a wheelchair at the dining room table eating lunch. *A Pull-Tab alarm was attached to the back of his wheelchair with a garment clip attached to the back of his shirt. Observation on 10/26/23 at 12:51 p.m. of resident 10 propelling his wheelchair back to his room from the dining room revealed: *He had a Pull-Tab alarm attached to the back of his wheelchair with a garment clip attached to the	F 657	Director of nursing or their designee will update the care-plans of residents 10,15, and 20 to reflect current use of Alarm devices by Dec.10,2023. To ensure other potentially affected residents are identified, all resident equipment/ devices will be audited and their care-plans will be updated by Dec. 10th 2023. Thereafter all equipment/devices and care-plan updates of all residents will be audited weekly for one month, then monthly thereafter for one year. These results will be reported by the DON to the administrator at the quarterly QA committee.	

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F 657	Continued From page 2 back of his shirt. Review of resident 10's medical record revealed: *He was admitted on 9/1/22. *Diagnoses included dementia and physical deconditioning. *He had a Brief Interview for Mental Status (BIMS) score of seven indicating severe impaired cognition. *He had a history of falls. *He had a fall with an injury on November 2022 that was listed on the provider's Matrix. *A 10/21/22 02:25 a.m. nurse note stated: "Resident continues to be weak and unsteady with treatment for hyponatremia, has had a recent fall, resident found transferring and ambulating independently but due to unsteady gait, tab alarm has been placed for resident safety as he is not using call light for assist." *A 4/14/23 physician signed and dated facsimile (fax) requesting an order for a Pull-Tab alarm. *A 9/15/23 fall risk assessment revealed he was at high risk for falls and listed a Pull-Tab alarm as a fall prevention intervention. *No documentation was found regarding family or the resident's representative had been notified that the Pull-Tab alarm had been implemented. *A review of the care plan revealed there was no documentation of the Pull-Tab alarm documented on the care plan. Interview on 10/26/23 at 10:37 a.m. with the Minimum Data Set (MDS) Coordinator C regarding Pull-Tab alarms revealed: *The process to initiate a Pull-Tab alarm would have been completed due to falls and the fall risk assessment. *Pull-Tab alarms were often implemented by the nurses and at night.	F 657	To ensure families of residents with alarm devices are notified prior to use, DON or their designee will ensure families of residents 10,15, and 20 sign informed consent for Protective Devices by Dec. 10 2023. To ensure all potential affected residents are identified, the DON or their designee will audit all equipment/devices and obtain consents by Dec.10 2023. The DON or their designee will audit all resident equipment/devices weekly for one month, then monthly thereafter for one year and report results to the administrator. To ensure Staff is fully informed of remedies for ensuring compliance with the Alarm devices Plan of Correction, a mandatory in-service will be held on no later than 10 December 2023. All staff will be educated on the Mobility positioning safety device evaluation in our updated restraint policy. Results of staff training will be reported to the administrator once 100% compliance is achieved.	

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F 657	Continued From page 3	F 657		

*The family member or representative had to have been notified when those Pull-Tab alarms were placed on the residents.
*She was unable to locate any documentation in the resident's medical record that his family was notified about the placement of a Pull-Tab alarm.
*She was unable to confirm that she had added the Pull-Tab alarm to the resident care plan.
*The fall risk assessment dated 9/15/23, had the Pull-Tab alarm listed as an intervention but they had no Pull-Tab alarm-specific assessments that were completed.
*There was no process to reassess the effectiveness of Pull-Tab alarms once they were implemented, they had no process in place to reassess if the Pull-Tab alarm was effective or ineffective for the resident.

Interview on 10/26/23 at 11:57 a.m. with registered nurse (RN) D regarding Pull-Tab alarms revealed:
*The nurse placed Pull-Tab alarms on residents when the nurse felt the resident was at high risk for falls and was unsafe.
*She was unsure if a physician's order for the Pull-Tab alarms were needed but the physician was usually notified by a fax to let them know about the Pull-Tab alarms.
*Generally, the family was notified by a phone call to let them know a Pull-Tab alarm was placed, which should have been documented in the residents medical record.
*There was a section in the medical record to document when the family member or their representatives were notified, and documentation of those phone calls were probably missed.
*Maybe it was not the policy to call, but she would have called them, so they were aware.
*They would let the MDS nurse know in the report

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F 657	Continued From page 4	F 657		

and may have written it in the care plan books when a Pull-Tab alarm was placed on a resident.
*She was not sure if a re-evaluation was needed or if it had been completed to continue the use of a Pull-Tab alarm.
*Once the Pull-Tab alarm was placed, they stayed.
*She had not been in a situation when once the Pull-Tab alarm was placed it had ever been removed.
*She believed that the Pull-Tab alarms resulted in fewer falls for residents.
*She stated when she heard a Pull-Tab alarm go off, she was up and on the move.

Interview on 10/26/23 at 1:02 p.m. certified nursing assistant (CNA) F regarding Pull-Tab alarms revealed:
*CNAs notified the nurses if they felt a resident needed a Pull-Tab alarm, if they were at risk of falling, or if there was a safety concern.
*The nurse might explain to the CNA to place the alarm, but the alarm would not have been placed unless the nurse directed it to have been placed.
*Most of the residents that had Pull-Tab alarms would not have been able to have been asked for their permission as they were confused.
*The nurse called the family to let them know the Pull-Tab alarm had been put on.
*They were told at the stand-up meetings when a new Pull-Tab alarm was placed for a resident.
*She was not aware when a Pull-Tab alarm had been re-evaluated, once a resident had a Pull-Tab alarm, they continued with it.

Interview on 10/26/23 at 1:21 p.m. with director of patient care B regarding Pull-Tab alarms revealed:
*There was no resident or resident representative

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F 657	Continued From page 5 signature for the informed consent with the placement of Pull-Tab alarms for residents. *She knew the Pull-Tab alarms could have been a mental restraint, but the policy was old-school thinking and had not addressed those Pull-Tab alarms as a resident restraint. *Pull-Tab alarms were placed mostly at night because residents were restless, had dementia, and had gotten their days and nights mixed up, or because residents had a lot of falls, despite providing other interventions such as distractions, having residents in a common area, and activities. *They had no Pull-Tab alarm policy, but the Avera Gregory Hospital had one she would get for the surveyor's request for a Pull-Tab alarm policy. *They had no Pull-Tab alarm assessments, and had not performed any formal assessments for those alarms. *Her expectation was the use of an alternate method should have been attempted and documented prior to the placement of a Pull-Tab alarm. *She expected family and physicians to have been notified when a Pull-Tab alarm was placed, and that should have been documented in the resident's medical record. *She expected that Pull-Tab alarms would have been reassessed for continued use with the completion of the MDS, documented on the care plan, and reviewed with the family at the care plan meetings. 2. Observation and interview on 10/24/23 at 3:03 p.m. with resident 15 in her room revealed: *She was seated in her wheelchair. *She enjoyed living at the facility. *She was not sure how long she had lived there. *Her family came to visit when they could. *She had a Pull-Tab alarm attached to the back of	F 657		

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F 657	Continued From page 6 her wheelchair and one placed on her bed. *Her plan was to return home. Review of resident 15's medical record revealed: *She was admitted on 9/19/23 and her diagnoses included the following: -Vascular dementia with behavioral disturbance. -Paranoid type delusional disorder. -Major neurocognitive disorder. *Her BIMS score was 4 which indicated severe cognitive impairment. *She had a history of falls. *Her care plan goal was to have no injuries from falls. *Her discharge goal was to remain at the facility long-term. *The care plan documented "Tab alarm to bed and wheelchair." *No documentation was found regarding family or family representative notification that those alarms were implemented. 3. Observation and interview on 10/25/23 at 9:43 a.m. with resident 20 in her room revealed she: *Was seated in her wheelchair. *Really enjoyed living here. *Thought she had lived there for a few months. *Had a Pull-Tab alarm attached to the back of her wheelchair. *Was not sure what the alarm was used for. Review of resident 20's medical record revealed: *She was admitted on 8/11/23 and her diagnoses included: -Alzheimer's. -Dementia without behaviors. -Anemia. -Depression. *Her BIMS score was 3 which indicated severe	F 657		

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F 657	Continued From page 7 cognitive impairment. *She had fallen on 8/22/23 and again on 9/17/23. *She had a Fall Risk Assessment completed on 8/16/23 with a score of 4 indicating she was a high fall risk. *Her care plan goal was to have no injuries from falls. *No documentation was found regarding family or family representative notification that the bed/chair Pull-Tab alarm had been implemented. Review of the [Name of the provider] 3/2022 Patient Restraints policy revealed: *" B. Alternatives to Restraints: Alternatives to restraints should be considered before restraint application. Some examples are: Frequent verbal instruction, bed alarm implementation, frequent observation, diversional activity, call light use re-explained, patient moved closer to the nurse's station, family at bedside, patient placed on fall risk precautions, sitter, reality orientation, mobility monitor implementation, one to one staffing, and rooms with video monitoring."	F 657		

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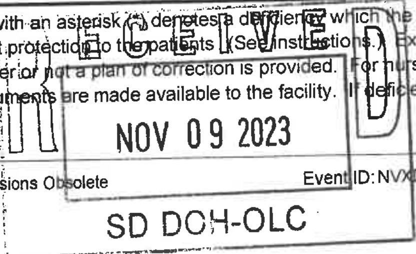
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 10/24/23 through 10/26/23. Avera Rosebud Country Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Timanus

TITLE: Administrator

(X6) DATE: 08Nov23

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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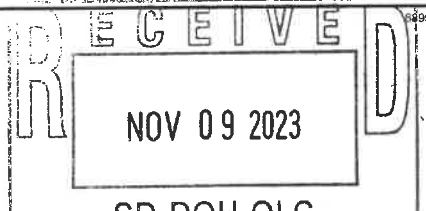
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/24/23 through 10/26/23. Avera Rosebud Country Care Center was found not in compliance with the following requirement: S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure an electrically audible alarm on all unattended exit doors was provided on four of four exit doors (main entrance, south wing exit door, north wing exit door, exit into the hospital). Findings include: 1. Observation on 10/24/23 at 12:45 p.m.	S 169	Main Entrance: We will install a badge reader on this door no later than 10DEC23. This will result in the door being locked when door is not attended and employees will let visitors in/out. We will use a tab alarm when the front reception desk is not attended until we install a badge reader on the door. The tab alarm will be placed high enough as so residents will not be able to reach. This will be monitored by the Charge Nurse. Alarm will be set when front reception desk cannot be attended and will be checked twice a day and once at night. Documented with time and initial's and will be reported to DON, ES manager weekly for four weeks until card reader is installed and reports taken to QA quarterly meetings. South wing door alarm will be tied into the nurse call system no later than 10DEC23. Until this is done charge nurse will check door daily. Findings will be dated and initialed turned into ES manager weekly for four weeks and reports brought to QA quarterly meetings. North wing door alarm will be tied into the nurse call system no later than 10DEC23. Until this is done charge nurse will check door daily. Findings will be dated and initialed turned into ES manager weekly for four weeks and reports brought to QA quarterly meetings. Door leading to hospital side will be tied into nurse call system no later than 10Dec23. Until this is done charge nurse will check door daily. Findings will be dated and initialed turned into ES manager weekly for four weeks and reports brought to QA quarterly meetings.	10DEC23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Timanus
TITLE: Administrator
(X6) DATE: 09Nov23



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S 169	Continued From page 1 revealed the door for the main exit was not locked and did not alarm when opened. Further observation at that same time revealed a reception desk inside that exit with no attendant present. Not having an attendant present left that door unalarmed, unlocked, and unattended. Interview with the director of environmental services director and the administrator at 4:15 p.m. in the exit interview confirmed that condition. 2. Observation and testing on 10/24/23 at 2:40 p.m. revealed the battery-operated alarm on the exit door for the south wing did not sound when the door was opened. Continued observation at that same time revealed the alarm box had been switched to the "off" position. The alarm box was further tested after being placed into the "on" position and did function correctly. Interview with the director of environmental services director at the time of the observation confirmed that condition. 3. Observation and testing on 10/24/23 at 2:45 p.m. revealed the battery-operated alarm on the exit door for the north wing did not sound when the door was opened. Continued observation at that same time revealed the alarm box had been switched to the "off" position. The alarm box was further tested after being placed into the "on" position and did function correctly. Interview with the director of environmental services director at the time of the observation confirmed that condition. 4. Observation and testing on 10/24/23 at 4:00 p.m. revealed the alarm on the exit door to the hospital did not sound when the door was	S 169		

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S 169	Continued From page 2 opened. Continued observation at that same time revealed the alarm was not alarming due to an adjustment issue. The alarm was further tested after being adjusted to operate when the door swinging into the hospital. Further testing of that door on 10/24/23 at 4:14 p.m. revealed that alarm was working, however that alarm would automatically silence after the door was closed. Interview with the director of environmental services director at 4:15 p.m. in the exit interview confirmed that condition.	S 169		
S 000	Compliance/Noncompliance Statement 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 10/24/23 through 10/26/23. Avera Rosebud Country Care Center was found in compliance.	S 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA ROSEBUD COUNTRY CARE CENTER	**126 S LOGAN AVE** **GREGORY, SD 57533**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 New health care occupancy) was conducted on 10/24/23. Avera Rosebud Country Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony Timanus	Administrator	08Nov23

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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