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
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/13/23 through 3/16/23. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F656, F689, and F812.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656	The facility does ensure to develop comprehensive person-centered plans of care for all residents. All residents are potentially at risk. Residents 17 & 27 care plans have been revised to be more person centered. Director of Nursing (DON) will educate the care plan team to ensure all care plans are more person-centered and individualized. Care plans will be reviewed and update as needed per the MDS schedule with all care plans being individualized and more person centered over the next quarter. The in-service will be completed by 4/14/23. DON or designee will complete 2 audits weekly X 4, then 4/month X 3 months. Results of the audits will be reported by the DON and discussed at the bi-monthly Quality Assurance Performance Improvment (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audits.	5/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske
TITLE: Administrator
(X6) DATE: 4/19/23

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.

RECEIVED
APR 19 2022
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 656	Continued From page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop comprehensive person-centered plans of care for two of two sampled residents (17 and 27). Findings include: 1. Observation and interview on 3/14/23 at 3:31 p.m. with resident 17 revealed: *He was seated in his wheelchair watching the television in his room. *He stated he had been living in the facility for many years. *When asked if he participated in the activities offered by the provider he stated "not really," but he enjoyed visiting with a few of the other male residents and he goes out to eat "every once in a while" with family. Review of resident 17's medical record revealed: *He was admitted on 7/13/16. *His diagnoses included cerebrovascular	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 656	Continued From page 2 accident, diabetes mellitus type II, pain, and depression. *His most recent brief interview for mental status (BIMS) indicated he was cognitively intact. *His most recent score on the mood assessment indicated minimal depression. *He was taking an antidepressant medication daily. *His 2/24/23 care conference progress note included the resident "requested a men's group every week or so ..." Review of resident 17's 3/15/23 care plan regarding activities, diabetes, and mood revealed: -No intervention was listed for his insulin injection. -No intervention addressed his antidepressant medication. -No intervention addressed his preference and request for socializing with other male residents. Interview on 03/15/23 02:59 PM with activity coordinator (AC) F revealed: *She had just started a men's group last month on 2/28/23 at 2:00 p.m. and resident 17 attended. *She stated she completed the assessments on the residents but is not involved in developing or revising the activity care plan. -She stated MDS nurse coordinator D developed the resident care plan from the assessments she completed. 2. Observation and interview on 3/14/23 at 11: 24 a.m. with resident 27 revealed she: *Was laying in bed with her bed clothes on with the television on and crossword puzzle books were on her overbed table next to her bed. *Had lived in the facility almost one year. *Stated she did not care to attend the group activity programs but preferred to watch television	F 656		

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
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 656	Continued From page 3 and do crossword puzzles in her room. Further interview with resident 27 on 3/14/23 at 1:28 p.m. revealed: *She was concerned with "putting on weight," stated she has "gained 30 pounds since being here," and that she mentioned she would like to lose weight to the nurses. Review of resident 27's medical record revealed: *She admitted on 3/30/22. *Her diagnoses included arthritis and frequent pain. *Her most recent BIMS coded her as cognitively intact. *Her 7/8/22 nutrition evaluation documented a three pound weight gain in the last 30 days and 11 pounds, 9.6 ounces weight gain since her admission. Review of resident 27's 3/16/23 care plan regarding activities and nutrition revealed: -No intervention addressed her preference to watch television and do crosswords in her room. -No intervention addressed her concern with gaining weight. Interview on 3/15/23 at 3:25 p.m. with MDS nurse coordinator D regarding care planning revealed she: *Developed and revised the care plans for the most part. *Agreed resident 17's care plan was not individualized for his: -Diabetes problem which had not included an intervention for his insulin injections he received daily. -Mood state which had not included an intervention for his antidepressant medication he	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 656	Continued From page 4	F 656		

received daily.
*Agreed resident 27's care plan had not addressed the resident's concern with gaining weight.
-She agreed with the 30 pounds of weight gain since her admission.
-She was not aware of the resident's weight concerns.
*Agreed there could be more collaboration with activities staff in the activity care plan.
*Agreed the care plans needed to be more individualized.

3. Interview on 3/16/23 at 8:33 a.m. with food service manager G regarding care planning revealed he attended the care conferences but the dietary department did not "formulate the care plan."

Interview on 3/16/23 at 9:00 a.m. with social services associate E revealed:
*She completed the social service assessments.
*She did not develop care plans for social service concerns, but relied on MDS nurse coordinator D to develop and revise individual care plans from the computerized assessments she completed.

Interview on 3/16/23 at 9:58 a.m. with MDS coordinator C revealed she agreed the care plans could be more individualized.

Interview on 3/16/23 at 11:17 a.m. with DON B revealed she:
*Agreed the care plans are generic.
*Stated their computer system made it easy to be generic and that it took effort to individualize the care plans.

4. Review of the provider's 8/2020 "Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 656	Continued From page 5 Planning" policy revealed: *"Policy: The interdisciplinary team will develop a baseline and comprehensive care plan for each resident, based on the admission assessments, assessment tools and the MDS assessment to provide effective and person-centered care of the resident that meet professional standards of quality care and to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being." *"Definitions:" -'"Person-centered care' - to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home."	F 656	The facility does ensure to prevent mattresses from shifting diagonally on the bed frames to avoid potential injury or entrapment. Mattress holders were placed on resident 46's bedframe to prevent mattress from shifting. TR 4/19/23 All residents' are potentially at risk. The Administrator and DON will educate the admission and care plan teams to ensure resident mattresses are secured and positioned appropriately on the bed frame and do not have the potential to cause injury or entrapment between the mattress and bed frame when using an assistance device by installing mattress holders on the bedframes TR 4/19/23. The in-service will be completed by 4/14/23.	5/4/23
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the provider failed to prevent one of one sampled resident (46) mattress from shifting	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 689	Continued From page 6 diagonally on the bed frame, thereby creating a potential area for injury or entrapment between the mattress and the bed frame. Findings include: 1. Observation and interview on 3/14/23 at 9:31 a.m. with resident 46 in her room revealed: *She had a cane-like grab bar on her bed frame in the up position. *Her mattress was positioned diagonally on the bed frame. -There was approximately a five- to six-inch gap between the mattress and the edge of the bed frame. -The metal springs of the bed frame were exposed. *She had not wanted to injure her skin on the metal springs or get stuck between the mattress and the grab bar, so she put one of her pillows in between the mattress and the grab bar. *Staff would at times readjust the mattress to be in line with the bed frame. *The mattress had been positioned diagonally for a couple of days. 2. Observation on 3/14/23 at 4:47 p.m. of resident 46's bed revealed the mattress was still positioned diagonally on the bed frame. 3. Observation and interview on 3/15/23 at 11:14 a.m. with resident 46 in her room revealed: *Her mattress was in line with the bed frame. *She expressed that she was glad someone had fixed it. -She stated someone must have adjusted the mattress when her bed was made that morning. 4. Interview on 3/15/23 at 3:36 p.m. with administrator A and resident 46 about the resident's bed revealed:	F 689	Administrator or designee will complete 3 random audits/week X 4, then 4 monthly X 3 to ensure resident's using an assistance device have a secure mattress that will not shift on the bedframe. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendation and/or continuation/discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 689	Continued From page 7 *Administrator A had been assisting the maintenance department with bed frame safety checks. -She had checked resident 46's bed frame on 2/17/23 and found that everything was in order. *Resident 46 said, "it was ridiculous," in reference to the sizable gap between the mattress and the edge of the bed frame. *Administrator A agreed that the mattress shifting around on the bed frame was a hazard. 5. Review of the provider's undated "Procedure Detail Report" for "Bedrail Safety Inspections" revealed: *"Inspect and [check] the [mattresses] and bedrails for areas of possible entrapment." *"Mattress should not have a gap wide enough to entrap a resident's head or body (4 ¾ [inches])." *"Check rails quarterly to ensure installed correctly and ensure rail has not shifted and loosened over time."	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	The facility does ensure to prevent potential cross-contamination when checking the temperatures of the food. All residents are potentially at risk. The Administrator and or Food and Nutrition Services (FNS) Manager will educate all FNS staff to ensure appropriate food temperature checks are completed to include sanitizing the thermometer prior to using and between each food temperature check to prevent any potential of cross-contamination. The in-service will be completed by 4/14/23.	5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 812	Continued From page 8 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to prevent potential cross-contamination when checking the temperatures of the food by nutrition and food service (NFS) staff H during one of one meal service observation. Findings include: 1. Observation on 3/15/23 at 4:53 p.m. of NFS H in the dining room service kitchen revealed: *After preforming hand hygiene, he retrieved two thermometers off of a shelf. *Without cleaning or sanitizing the first thermometer he: -Put the probe of the thermometer into the vegetable soup. -Without cleaning or sanitizing the probe he then placed the probe into the mashed potatoes and then the gravy. *Without cleaning or sanitizing the second thermometer he: -Put the probe of the thermometer into the corn. -Without cleaning or sanitizing the probe he then placed the probe into the breaded pork cutlet and then the pureed port cutlet. *When he had completed taking the food temperatures, he cleansed the probes with an alcohol-based thermometer wipe and placed the thermometers back on the shelf. 2. Interview on 3/15/23 at 5:59 p.m. with NFS H about his process for checking food temperatures for the meal service revealed:	F 812	FNS Manager or designee will complete 3 audits per week X 4, then 1 audit per week X 3 months to ensure food temperature checks are completed correctly to prevent cross-contamination. Results of the audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 812	Continued From page 9	F 812		

*Before starting the food service, he would have washed his hands.
*He would poke a hole in the plastic and/or aluminum foil covering over each food item.
*He would wait until the temperature reading on the thermometer slowed down and he would record the food temperature on the temperature sheet.
*He would repeat the process until all the food temperatures had been checked.
*To justify not cleaning or sanitizing the thermometer probe in between each food item, NFS H stated he would temp the foods with the highest amount of potential allergens last so as not to contaminate the other foods with allergens.

3. Interview on 03/16/23 at 8:50 a.m. with food service manager G about the above observation and interview with NFS H revealed he:
*Was not aware NFS H was not sanitizing the thermometer probes between each food temperature check.
*Expected NFS H to perform appropriate food temperature checks due to his extensive food service experience.
*NFS staff needed more training on food safety and preventing cross-contamination.

4. Review of the provider's February 2021 "Food Preparation" policy revealed:
*Under the "PROCEDURE" section:
-"11. Wipe post of thermometer with disposable alcohol swab - wait 30 seconds to insert post into food. Wipe post between all items to prevent possible cross contamination."

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
	435034	A. BUILDING _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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
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 3/13/23 through 3/16/23. Avera Maryhouse Long Term Care was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske
TITLE: Administrator
(X6) DATE: 4/3/23

RECEIVED
APR 04 2022
SD DOH-OLC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/14/23. Avera Maryhouse Long Term Care (Building 1) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/16/23. Please mark an F in the completion date column for K226 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=C	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, testing, interview, and	K 226		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske

TITLE: Administrator

(X6) DATE: 3/31/23

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.

RECEIVED
APR 04 2022
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 226	Continued From page 1 document review, the provider failed to maintain ninety-minute horizontal exit doors in operating condition. The horizontal doors separating building 01 and building 02 on the second floor when closed provided a gap clearance between the door and the floor greater than 3/4 inch. Findings include: 1. Observation and testing on 3/14/23 at 9:45 a.m. revealed the cross-corridor horizontal exit doors separating building 02 and building 01 on the second 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 supervisor of facility services 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 dated 11/16/21 confirmed the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 226		
K 712	Fire Drills	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 712 SS=E	Continued From page 2 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to a smoke protected area and closing corridor doors). Findings include: 1. Observation on 3/14/23 at 11:30 a.m. revealed the nurse call in resident room 203 was initiated by the maintenance supervisor. The staff person responding to the call light in the room was told by the maintenance supervisor that a fire drill had been initiated. The staff person utilized a wheelchair and removed the resident from the room, but did not close the door after resident removal. The staff person also did not move the resident to a different smoke tight compartment such as another room or beyond the smoke barrier doors until instructed to do so by the facilities manager three minutes into the drill. After relocating the resident, the staff had been instructed by the facilities manager to sound the fire alarm. The alarm was sounded and an announcement was made on the overhead	K 712	The facility does ensure staff are familiar with our fire drill procedures. All residents are potentially at risk. The facility will complete fire drills weekly X 6 weeks, then every other week for 10 weeks to ensure staff have knowledge of procedures to include moving residents to a smoke protected area and closing corridor doors. Administrator or designee will observe and retrain if any deficient practice observed during each drill. Administrator and DON will educate all staff on the facility's fire drill procedures. This in-service will be completed by 4/21/23. Results of these audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits	5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 712	Continued From page 3 intercom system at 11:35 a.m. Several responding staff persons brought fire extinguishers to the simulated fire location and checked for residents in the corridor and sunroom. Several corridor doors were not during the response period, including rooms 205, 206, 207, and 209. That was pointed out after the 'all clear' was announced. Interview with the maintenance supervisor and facilities director at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 712		

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
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/14/23. Avera Maryhouse Long Term Care (Building 2) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 13/16/23. Please mark an F in the completion date column for K226 and K311 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=C	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, testing, interview, and	K 226		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Talli Raske | Administrator | 3/31/23

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.

RECEIVED
APR 04 2022
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 226	Continued From page 1 document review, the provider failed to maintain ninety-minute horizontal exit doors in operating condition. The horizontal doors separating building 01 and building 02 on the second floor when closed provided a gap clearance between the door and the floor greater than 3/4 inch. Findings include: 1. Observation and testing on 3/14/23 at 10:30 a.m. revealed the cross-corridor horizontal exit doors separating building 02 and building 01 on the second 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 supervisor of facility services 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 dated 11/18/21 confirmed the condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 226		
K 311	Vertical Openings - Enclosure	K 311		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 311 SS=C	Continued From page 2 CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING 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 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: 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 on 3/14/23 at 10:15 a.m. 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 deficiency affected one of numerous requirements for maintaining protected paths of egress. 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 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to a smoke protected area and closing corridor doors). Findings include: 1. Observation on 3/14/23 at 11:30 a.m. revealed the nurse call in resident room 203 was initiated by the maintenance supervisor. The staff person responding to the call light in the room was told by the maintenance supervisor that a fire drill had been initiated. The staff person utilized a wheelchair and removed the resident from the room, but did not close the door after resident removal. The staff person also did not move the resident to a different smoke tight compartment such as another room or beyond the smoke barrier doors until instructed to do so by the facilities manager three minutes into the drill. After relocating the resident, the staff had been instructed by the facilities manager to sound the fire alarm. The alarm was sounded and an announcement was made on the overhead	K 712	The facility does ensure staff are familiar with our fire drill procedures. All residents are potentially at risk. The facility will complete fire drills weekly x 6 weeks, then every other week for 10 weeks to ensure staff have knowledge of procedures to include moving residents to a smoke protected area and closing corridor doors. Administrator or designee will observe and retrain if any deficient practice observed during each drill. Administrator and DON will educate all staff on the facility's fire drill procedures. This in-service will be completed by 4/21/23. Results of these audits will be reported by the Administrator or designee and discussed at the bi-monthoy QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits.	5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 712	Continued From page 4 intercom system at 11:35 a.m. Several responding staff persons brought fire extinguishers to the simulated fire location and checked for residents in the corridor and sunroom. Several corridor doors were not during the response period, including rooms 205, 206, 207, and 209. That was pointed out after the 'all clear' was announced. Interview with the maintenance supervisor and facilities director at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 712		

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
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/14/23. Avera Maryhouse Long Term Care (Building 3) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/16/23. Please mark an F in the completion date column for K311 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 311 SS=C	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING 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 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.	K 311		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske
TITLE: Administrator
(X6) DATE: 3/31/23

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.

RECEIVED
APR 04 2022
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 311	Continued From page 1 This REQUIREMENT is not met as evidenced by: 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 activities room and the southeast stairs). Findings include: 1. Observation during the survey on 3/14/23 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 activities room on the first and second floors. *To the stair enclosures east of the activity room on the first and second floors. *To the southeast stair enclosures on the first and second floors. Review of the previous life safety code survey dated 11/16/21 confirmed that condition had existed since the original construction. The deficiency affected one of numerous requirements for fire-rated door assemblies. 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 311		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 712	Continued From page 2 signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to a smoke protected area and closing corridor doors). Findings include: 1. Observation on 3/14/23 at 11:30 a.m. revealed the nurse call in resident room 203 was initiated by the maintenance supervisor. The staff person responding to the call light in the room was told by the maintenance supervisor that a fire drill had been initiated. The staff person utilized a wheelchair and removed the resident from the room, but did not close the door after resident removal. The staff person also did not move the resident to a different smoke tight compartment such as another room or beyond the smoke barrier doors until instructed to do so by the facilities manager three minutes into the drill. After relocating the resident, staff were instructed by the facilities manager to sound the fire alarm. The alarm was sounded and an announcement was made on the overhead intercom system at 11:35 a.m. Several responding staff persons brought fire extinguishers to the simulated fire location and checked for residents in the corridor and sun room. Several corridor doors were not	K 712	The facility does ensure staff are familiar with our fire drill procedures. All residents are potentially at risk. The facility will complete fire drills weekly X 6 weeks,then every other week for 10 weeks to ensure staff have knowledge of procedures to include moving residents to a smoke protected area and closing corridor doors. Administrator and DON will educate all staff on the facility's fire drill procedures. This in-service will be completed by 4/21/23. Results of these audits will be reported by the Administrator or designee and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits.	5/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435034	A. BUILDING **03 - BUILDING 03** B. WING _____	**03/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	**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 712	Continued From page 3 during the response period, including rooms 205, 206, 207, and 209. This was pointed out after the 'all clear' was announced. Interview with the maintenance supervisor and facilities director at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 712		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10662	A. BUILDING: _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MARYHOUSE LONG TERM CARE	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 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/13/23 through 3/16/23. Avera Maryhouse Long Term Care was found in compliance.	S 000		
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 3/13/23 through 3/16/23. Avera Maryhouse Long Term Care was found in compliance.	S 000		

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

Talli Raske

TITLE

Administrator

(X6) DATE

4/3/23

RECEIVED
APR 04 2022
SD DOH-OLC