

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

PRINTED: 11/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/28/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  Surveyor: 41088 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/26/21 through 10/28/21. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirement: F700.	F 000			
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4)  §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.  §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.  §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure	F 700	Restraint Policy N-554 reviewed and revised to include: <ul style="list-style-type: none"> <li>Review risks and benefits of side rails/grab bars with resident and/or representative and obtain an informed consent prior to installation of side rails/ grab bars.</li> <li>Attempt to use appropriate alternatives prior to installing side rail / grab bar. Assess resident for risk of entrapment from bed rail prior to installation.</li> <li>Ensure the bed's dimensions are appropriate for the resident's size and weight.</li> <li>Manufacturers' recommendations and specifications for installing and maintaining side rails/ grab bars is followed.</li> </ul> Pre-restraint assessment intervention and check list will be completed on all new admissions starting with the next new admission.	11/16/2021	

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

*Tom Snyder*

TITLE

Administrator

(X6) DATE

11/17/2021

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

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NAME OF PROVIDER OR SUPPLIER  <b>avera mother joseph manor retirement community</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
(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 700	Continued From page 1 safety assessments were completed and documented for 6 of 18 sampled residents (4, 11, 16, 31, 44 and 57) who had side rails on their beds. Findings include:  1. Observation on 10/27/21 at 9:43 a.m. of resident 11's bed revealed bilateral side rails near the head of the bed. *The side rail by the wall was in the upright position and the other side rail was down.  Interview on 10/27/21 at 9:45 a.m. with resident 11 revealed: *She had used the side rails for positioning herself in bed. *The side rails had been on her bed since her admission. *She could not remember education being provided for risks of the bed rails or signing a consent form for their use.  Review of resident 11's medical record revealed: *She had been admitted on 2/15/21. *Her brief interview for mental status (BIMS) was 15 and indicated her cognition was intact. *A 2/15/21 physician order for side rails to aid with bed mobility. *Her last revised care plan stated she used side rails for bed mobility.  2. Observation and interview on 10/26/21 at 7:55 a.m. with resident 16 revealed she: *Had been lying in her bed with bilateral side rails near the head of the bed and both side rails were up. *Used the side rails to hold herself up when staff assisted her with care and to reposition. *Thought the side rails had been on her bed since her admission.	F 700	All current Residents, including but not limited to residents ( #4,11,16,31,44 & 57 ) will have a side rail / grab bar assessment completed in EMR by 12/14/2021.  Side rails/grab bars will be removed from beds by 12/14/2021. If side rails/grab bars are unable to be removed from bed, they will be secured in the down position.  If side rail or grab bar deemed necessary, they will remain on the bed and an assessment will be done by DON, ADON or designee measuring to insure gaps/widths between handles on devices and space between mattress and side rail are less than 4 ¾ inches, per policy to decrease risk of entrapment by 12/14/2021.  Care Plans will be reviewed, revised and individualized for all residents to reflect side rail/grab bar use or non-use by 12/14/2021 and then quarterly and with change of condition thereafter.  All beds utilized by Residents will have an initial inspection by DON, ADON or designee to ensure dimensions are appropriate for the Residents size and weight by 12/14/2021, then annually going forward.  Maintenance to inspect all beds containing side rails / grab bars to assure manufacturers' recommendations and specifications for installing and maintaining bed rails is compliant by 12/14/2021, then annually thereafter with PM checks.  Education will be provided to all nursing staff by Staff Development Coordinator or designee on restraints and side rail/bed rail policies by 12/14/2021.	12/14/2021

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F 700	<p>Continued From page 2</p> <p>*Could not recall education being provided regarding risks of the bed rails or if she had signed a consent for their use.</p> <p>Observation on 10/27/21 at 9:31 a.m. of resident 16 in bed with her eyes closed with both side rails in the upright position.</p> <p>Review of resident 16's medical record revealed: *She had been admitted on 12/13/20. *She had been on hospice since May 2021. *Her BIMS score was 10 indicating she had a moderate cognitive impairment. *A 12/13/20 physician's order for side rails to aid in bed mobility. *Her last revised care plan stated she used side rails for bed mobility.</p> <p>3. Observation on 10/26/21 at 8:05 a.m. and 10/27/21 at 9:22 a.m. with resident 31 in a bed with bilateral side rails, her eyes closed and both side rails up.</p> <p>Review of resident 31's medical record revealed: *She had been admitted on 6/9/21. *Her BIMS score was three indicating severe cognitive impairment. *A 6/9/21 physician's order for side rails to aid in bed mobility. *Her last revised care plan stated she used side rails for bed mobility.</p> <p>4. Observation on 10/26/21 at 7:40 a.m. of resident 57's bed with bilateral side rails near the head of the bed, and the bed rail next to the wall had been in the upright position.</p> <p>Interview on 10/28/21 at 10:31 a.m. with certified</p>	F 700	<p>Monthly audits of Pre-restraint Assessments completion compliance on all new admissions will be completed by DON, ADON or designee x6 months.</p> <p>Monthly audits of informed consent obtained for use of side rail/grab bar ( bed mobility ) on all new admits will be completed by DON, ADON or designee x6 months.</p> <p>Monthly audits of care plans for residents with side rails / grab bars on all new admits will be completed by DON, ADON or designee to assure documentation is on the care plan for side rail/grab bar ( bed mobility ) x6 months.</p> <p>Ten (10) monthly audits will be completed by DON, ADON or designee of staff compliance with appropriate use of side rails/grab bars ( bed mobility ) x6 months</p> <p>Audits will be reported quarterly x2 to the QAPI Committee by ADON or until advised to discontinue reporting by QAPI Committee.</p>	

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F 700	<p>Continued From page 3</p> <p>nursing assistant (CNA) E revealed:</p> <ul style="list-style-type: none"> <li>*They put the side rails up for all the residents if they are in bed for safety so they did not fall.</li> <li>*For more information they looked at the care plans for specific instructions such as if there should be one or both side rails up or down for the resident.</li> </ul> <p>Interview on 10/28/21 at 10:44 a.m. with resident 57 revealed:</p> <ul style="list-style-type: none"> <li>*She used the side rails every day to get into bed.</li> <li>*The bed rails assist her to be able to turn over and change position.</li> <li>*They do not bother her.</li> <li>*The staff put the bed rails up before she goes to bed each night.</li> </ul> <p>Review of resident 57's medical record revealed:</p> <ul style="list-style-type: none"> <li>*She had been admitted on 1/6/21.</li> <li>*Her BIMS score was 15 indicating she was cognitively intact.</li> <li>*A 1/6/21 physician order for side rails to be used to enable bed mobility and transfers.</li> <li>*Her last revised care plan stated she used side rails for bed mobility and transfers.</li> </ul> <p>Review of the above care plans revealed no specific information about placement of the side rails for the residents.</p> <ul style="list-style-type: none"> <li>-There was no mention of whether one side rail or both was to be used.</li> <li>-There was no mention of what diagnosis or condition had prompted the need for the side rails.</li> </ul> <p>Review of the medical records of the above residents revealed:</p> <ul style="list-style-type: none"> <li>*Side rail safety assessments had not been completed to ensure:</li> </ul>	F 700			

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F 700	<p>Continued From page 4</p> <p>-The risks and benefits had been reviewed with the resident or their representative. -The provider received signed consent for side rails before their use. *Appropriate alternative interventions had been attempted prior to side rails being used.</p> <p>Surveyor: 43021 5. Observation and interview with resident 44, on 10/26/21 at 10:45 a.m. revealed: *Bilateral side rails towards the head of her bed. *She has side rails "so I don't fall out" and uses them to turn over when in bed. *She does not recall staff discussing the risks and benefits of using the side rails.</p> <p>Review of resident 44's medical record revealed: *She had been admitted on 12/30/20. *Her BIMS of 15 indicated her cognition was intact. *A 12/30/20 physician order for side rails to enable bed mobility and transfer. *Her last revised care plan on 9/30/21 stated she used partial side rails to enable bed mobility and transfers.</p> <p>6. Observation on 10/27/21 at 8:10 a.m. of resident 4 in her bed revealed raised bilateral side rails towards the head of her bed.</p> <p>Review of resident 4's medical record revealed: *She had been admitted on 5/13/21. *Her MDS revealed a BIMS score of 3 indicating severe cognitive impairment. Her BIMS of 3 indicated her cognition was severely impaired. *A 5/13/21 physician order for side rails to enable bed mobility and transfer. *Her last revised care plan on 8/5/21 stated she</p>	F 700		

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F 700	<p>Continued From page 5</p> <p>used partial side rails to enable bed mobility and transfers.</p> <p>Review of residents 4 and 44's medical records further revealed:</p> <ul style="list-style-type: none"> <li>*No assessment was completed before side rails were used.</li> <li>*No consent form was signed.</li> <li>*No education on the risks associated with side rails were documented.</li> <li>*No quarterly assessment was completed regarding side rail usage.</li> <li>*Use of the side rails was not reviewed quarterly at the care conference.</li> </ul> <p>Interview on 10/26/21 at 4:49 p.m. with resident care supervisor (RCS) B revealed the following regarding provider's side rails:</p> <ul style="list-style-type: none"> <li>*The bed controls for their electric beds were a part of the side rail.</li> <li>*The current practice was to leave the side rails on the beds.</li> <li>*She stated the side rails help residents maintain their bed mobility.</li> <li>*She stated there was "no real side rail assessment in Meditech," the provider's electronic medical record (EMR).</li> </ul> <p>Interview on 10/27/21 at 8:34 a.m. with housekeeper D when asked about how many of the beds have side rails, he replied "I don't think there is a bed that doesn't have them."</p> <p>Interview with RCS B and RCS C on 10/28/21 at 9:21 a.m. revealed:</p> <ul style="list-style-type: none"> <li>*RCS B stated:</li> <li>-No assessments were completed to address the side rails.</li> <li>-She did not view side rails as a restraint but felt</li> </ul>	F 700		

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F 700	<p>Continued From page 6</p> <p>that they were used to maintain independence.</p> <ul style="list-style-type: none"> <li>-The resident and or family member do not sign a consent for the use of the side rail.</li> <li>-She could not show documentation where the resident and family were educated on the risk.</li> </ul> <p>Medical record review and interview with RCS B on 10/28/21 at 9:30 a.m. regarding the provider's EMR revealed and confirmed:</p> <ul style="list-style-type: none"> <li>*She was aware of the provider's August 2020 Restraint Policy.</li> <li>*There was a pre-restraint assessment available in the provider's EMR.</li> <li>*This assessment included: <ul style="list-style-type: none"> <li>-Device type (side rails were one of the fifteen devices listed on the checklist).</li> <li>-Consent/orders, where staff could indicate a consent was signed</li> <li>-Education provided to resident and family.</li> </ul> </li> <li>*There was a restraint assessment available in the provider's EMR.</li> <li>*This assessment included the following statements where staff could indicate yes or no and add a comment: <ul style="list-style-type: none"> <li>-Currently using side rail.</li> <li>-Are devices used considered a restraint.</li> </ul> </li> <li>*Neither of these assessments were currently being used to assess side rails.</li> <li>*RCS B stated the pre-restraint assessment could be added to the admission set.</li> <li>*RCS B stated they are not completing a quarterly assessment of the side rails.</li> <li>*RCS B confirmed the use of these assessments were the policy for side rails.</li> <li>*The care conference summary was completed by the resident care coordinators.</li> <li>-Included a section for safety device or restraint review.</li> <li>*RCS B stated that the topic of side rails was not</li> </ul>	F 700		

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F 700	Continued From page 7 currently discussed at the care conference. *RCS B confirmed she was not following the provider's August 2020 Restraint Policy regarding side rails.  Interview with director of nursing A on 10/28/21 at 9:58 a.m. confirmed: *Side rails were on most of the beds in the facility. *Admission process included side rails on the standing orders obtained from the physician. *She was aware of the requirement to complete assessments when using side rails. *Confirmed side rail assessments had not been completed.  Review of the provider's August 2020 Restraint Policy regarding side rails revealed: *Side rails will not be offered as part of routine care. *Before utilizing side rails a pre-restraint assessment will be completed to ensure the resident's safety of the device. *If the resident is determined to be able to use the device safely the interdisciplinary team will educate the resident on the risk associated with side rail use and alternatives available such as a repositioning or assist bar. *A quarterly assessment will be documented in the restraint assessment. *Use of the device will be reviewed quarterly by the interdisciplinary team, resident, and family at the care conferences.	F 700		



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E 000	Initial Comments  Surveyor: 41088 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 10/26/21 through 10/28/21. Avera Mother Joseph Manor Retirement Community was found in compliance.	E 000			

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

TITLE

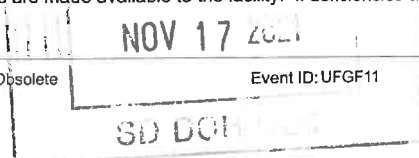
(X6) DATE

*X Tom Snyder*

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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/26/21. Avera Mother Joseph Manor Retirement Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies and the Fire Safety Evaluation System (FSES) dated 10/28/21 upon correction of the deficiencies identified below.  Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES.  The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321, K353, K918, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards	K 000		F	
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101  Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced	K 241		F	

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Administrator

(X6) DATE

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

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

PRINTED: 11/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
(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 241	Continued From page 1 by: Surveyor: 18087 Based on observation and record review, the provider failed to maintain a one-hour, fire-resistive path of egress from the second level to the exterior of the building. Two randomly observed stair enclosures discharged into the main level corridor system. Findings include:  1. Observation on 10/26/21 at 9:30 a.m. revealed the east and west second level stair enclosures discharged into the main level corridor system. A one-hour, fire-resistive path of egress was not provided to the exterior of the building. Review of the previous life safety code survey confirmed that finding.  The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 241		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101  Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321	The transfer grill in the noted electrical room was removed on 11/16 and the opening was sealed with double 5/8th inch fire rated drywall. Electrical & mechanical rooms will be added to the monthly fire extinguisher PM and will be checked and audited for fire separation openings. Any openings found will be properly sealed.  Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	11/24/2021

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>		
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K 321	<p>Continued From page 2 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation and interview, the provider failed to maintain the fire-resistive design of one of two building separation walls (between the generator electrical room and the exit discharge vestibule). Findings include:</p> <p>1. Observation on 10/26/21 at 10:30 a.m. revealed the two-hour fire-rated separation wall between the generator electrical room and the exit discharge vestibule had a transfer grille opening above the ninety-minute fire-rated door. The transfer grille opening was approximately twelve inches by eighteen inches and was an unacceptable installation that bypassed the fire rating of the wall.</p> <p>Interview with the maintenance staff at the time of the observation confirmed that finding.</p> <p>The deficiency could affect 100% of the occupants of the smoke compartment.</p>	K 321		

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
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K 353 K 353 SS=E	Continued From page 3 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain the automatic fire sprinkler system as required by the National Fire Prevention Association (NFPA) Section 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (three-year leak test and survey for GB QR heads). Findings Include:  1. Review on 10/26/21 at 10:30 a.m. of the provider's sprinkler maintenance records revealed reports dated 6/7/21 and 10/1/21 from the contractor stating recommendations to perform the required three-year leak test of the	K 353 K 353	The facility Plant Operations Director will review fire sprinkler inspection reports and promptly schedule repairs or services recommended in the reports.  Western States has been contacted and the noted 3 year leak test is scheduled for November 23, 2021.  Sprinkler Inspection Reports will be audited by the Plant Operations Director upon receipt for recommendations and scheduling of needed services.  Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	11/24/2021

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K 353	Continued From page 4 dry systems and a survey for the quick response sprinkler heads (from the 6/7/21 report). There was no documentation this recommendation had been acted upon or performed.  Interview with the maintenance staff at the time of the document review revealed the status of the recommendations were unknown.  The deficiency affected two components of the building's automatic fire sprinkler system required maintenance.	K 353			
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101  Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation, measurement, and record review, the provider failed to maintain at least 32 inches of clear width for one set of randomly observed smoke barrier doors (between the 1961 original building and the 1980 addition) opening.	K 374		F	

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NAME OF PROVIDER OR SUPPLIER  <b>avera mother joseph manor retirement community</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
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K 374	Continued From page 5 Findings include:  1. Observation on 10/26/21 at 9:45 a.m. revealed the cross-corridor doors from the 1961 original building and the 1980 addition measured 30 inches in clear width. Review of the previous survey report revealed those doors were part of the original construction.  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 374		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	K 918	Generator Load tests will be conducted as required. The Generator periodic test forms have been revised to simplify recordation of required Load tests. 3E – Electrical, Engineering & Equipment Co. provided generator operation & testing training on November 12, 2021 to Plant Operations staff that included load test documentation.  Generator testing forms will be audited by the Plant Operations Director upon completion for documentation of required testing and normal operation settings.  Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	11/24/2021



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K 918	Continued From page 6 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to document the generator load percentage of nameplate during monthly load testing from January 2021 through October 2021. Findings include:  1. Record review on 10/26/21 at 11:10 a.m. revealed there was not any documentation of the percentage of generator nameplate value carried under load by the 125 kilowatt diesel Kohler generator during the monthly load tests from January 2021 through October 26, 2021. Further review of the generator documentation revealed a formula on it that would allow the provider to compute the percentage of load data that was required. Interview with the maintenance staff at the time of the documentation confirmed that finding.  The deficiency affected 100% of the building occupants.	K 918			
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923			

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K 923	Continued From page 7  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923	The oxygen storage rooms will comply with the stated regulations. The combustible materials and wood shelf have been removed from the B Wing oxygen room noted.  Oxygen storage rooms will added to the weekly HVAC PM schedule and be audited weekly by the Plant Operations staff for compliance with the storage requirements.  Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	11/24/2021

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NAME OF PROVIDER OR SUPPLIER  <b>avera mother joseph manor retirement community</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>		
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K 923	<p>Continued From page 8</p> <p>Surveyor: 18087</p> <p>Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored on a shelf within five feet of the oxygen cylinders in the B wing oxygen storage room. Findings include:</p> <p>Observation on 10/26/21 at 11:00 a.m. revealed combustible materials were stored on a wood shelf above and within five feet of 47 oxygen cylinders in the B wing oxygen storage room. The minimum five feet of separation between combustibles and oxygen storage were not maintained as required in this area.</p> <p>The deficiency affected one of four smoke compartments.</p>	K 923		



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NAME OF PROVIDER OR SUPPLIER  <b>avera mother joseph manor retirement community</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/26/21. Avera Mother Joseph Manor Retirement Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K353 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	The facility Plant Operations Director will review fire sprinkler inspection reports and promptly schedule repairs or services recommended in the reports.  Western States has been contacted and the noted 3 year leak test is scheduled for November 23, 2021.  Sprinkler Inspection Reports will be audited by the Plant Operations Director upon receipt for recommendations and scheduling of needed services.  Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	11/24/2021

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

TITLE

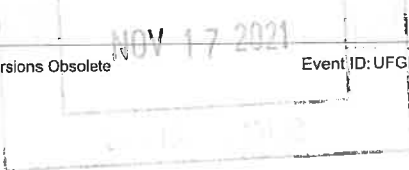
(X6) DATE

*Tom Snyder*

Administrator

11/17/2021

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



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K 353	Continued From page 1 by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain the automatic fire sprinkler system as required by the National Fire Prevention Association (NFPA) Section 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (three-year leak test and survey for GB QR heads). Findings Include:  1. Review on 10/26/21 at 10:30 a.m. of the provider's sprinkler maintenance records revealed reports dated 6/7/21 and 10/1/21 from the contractor stating recommendations to perform the required three-year leak test of the dry systems and a survey for the GB quick response sprinkler heads (from the 6/7/21 report). There was no documentation this recommendation had been acted upon or performed.  Interview with the maintenance staff at the time of the document review revealed the status of the recommendations were unknown.  The deficiency affected two components of the building's automatic fire sprinkler system required maintenance.	K 353		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918	Generator Load tests will be conducted as required. The Generator periodic test forms have been revised to simplify recordation of required Load tests. 3E – Electrical, Engineering & Equipment Co. provided generator operation & testing training on November 12, 2021 to Plant Operations staff that included load test documentation.	11/24/2021

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>		
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K 918	<p>Continued From page 2</p> <p>process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 18087</p> <p>Based on record review and interview, the provider failed to document the generator load percentage of nameplate during monthly load testing from January 2021 through October 2021. Findings include:</p> <p>1. Record review on 10/26/21 at 11:10 a.m. revealed there was not any documentation of the</p>	K 918	<p>Generator testing forms will be audited by the Plant Operations Director upon completion for documentation of required testing and normal operation settings.</p> <p>Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.</p>	

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

PRINTED: 11/09/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>2A - SOUTHWEST WING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/26/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>		
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K 918	Continued From page 3 percentage of generator nameplate value carried under load by the 125 kilowatt diesel Kohler generator during the monthly load tests from January 2021 through October 26, 2021. Further review of the generator documentation revealed a formula on it that would allow the provider to compute the percentage of load data that was required. Interview with the maintenance staff at the time of the documentation confirmed that finding.  The deficiency affected 100% of the building occupants.	K 918			



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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/26/21. Avera Mother Joseph Manor Retirement Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K353 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	The facility Plant Operations Director will review fire sprinkler inspection reports and promptly schedule repairs or services recommended in the reports.  Western States has been contacted and the noted 3 year leak test is scheduled for November 23, 2021.  Sprinkler Inspection Reports will be audited by the Plant Operations Director upon receipt for recommendations and scheduling of needed services.  Audit results will be reported quarterly to the QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	11/24/2021

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

*Tom Snyder*

TITLE

Administrator

(X6) DATE

11/17/2021

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

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 NORTH JAY STREET ABERDEEN, SD 57401</b>	
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K 353	Continued From page 1 by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain the automatic fire sprinkler system as required by the National Fire Prevention Association (NFPA) Section 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (three-year leak test and survey for GB QR heads). Findings Include:  1. Review on 10/26/21 at 10:30 a.m. of the provider's sprinkler maintenance records revealed reports dated 6/7/21 and 10/1/21 from the contractor stating recommendations to perform the required three-year leak test of the dry systems and a survey for the GB quick response sprinkler heads (from the 6/7/21 report). There was no documentation this recommendation had been acted upon or performed.  Interview with the maintenance staff at the time of the document review revealed the status of the recommendations were unknown.  The deficiency affected two components of the building's automatic fire sprinkler system required maintenance.	K 353		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918	Generator Load tests will be conducted as required. The Generator periodic test forms have been revised to simplify recordation of required Load tests. 3E – Electrical, Engineering & Equipment Co. provided generator operation & testing training on November 12, 2021 to Plant Operations staff that included load test documentation.	11/24/2021

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10590</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/28/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MOTHER JOSEPH MANOR RETIREMENT COM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 N JAY STREET ABERDEEN, SD 57401</b>
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S 000	Compliance/Noncompliance Statement  Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/26/21 through 10/28/21. Avera Mother Joseph Manor Retirement Community was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement  Surveyor: 41088 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 10/26/21 through 10/28/21. Avera Mother Joseph Manor Retirement Community was found in compliance.	S 000		

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

*Tom Snyder*

STATE FORM

TITLE

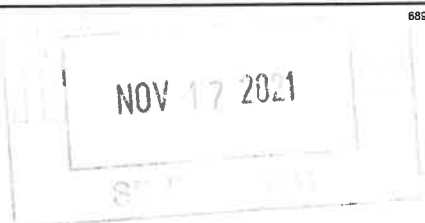
Administrator

G3OM11

(X6) DATE

11/17/2021

If continuation sheet 1 of 1



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