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 _____	11/18/2021

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 Surveyor: 41895 A recertification health survey and a COVID-19 Focused Infection Control Survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/16/21 through 11/18/21. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: F700, F761, and F880.	F 000		
F 700 SS=D	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	F 700	The facility does ensure all residents have received risks versus benefits education for side rail use, have obtained a signed informed consent form for side rail use and will perform regular safety checks for the proper installation of side rails. All residents are potentially at risk. Residents 15, 28, 29, 37, ad 48 were reviewed for the above requirements and are all now compliant. Resident 27 was assessed and does not have a need for use of a side rail. The side rail is zip tied to the bedframe as it is not able to be removed. Safety checks for proper installation were completed on all side rails. Director of Nursing (DON) or Administrator will educate the care plan team, and all direct care staff on the requirement that any resident using a side rail must first have received risks versus benefits education and have a signed consent form prior to use.	1/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Talli Raske	Adminstrator	12/9/21

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 _____ B. WING _____	11/18/2021

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 700	Continued From page 1 Based on observation, interview, record review, and policy review, the provider failed to ensure six of twelve sampled residents (15, 27, 28, 29, 37 and 48) had: *Received risks versus benefits education for side rail use. *Obtained signed informed consent forms for side rail use. *Performed regular safety checks for the proper installation of side rails. Findings include: 1. Observation and interview on 11/17/21 at 3:37 p.m. with resident 15 revealed she: *Had a side rail on the upper part of her bed which was in the upright position. *Used it to reposition or roll over in bed. *Stated the staff put the side rail up and down for her as she could not. *Could not remember staff educating her on the risks or benefits of the side rails or signing a consent form for their use. *Thought the side rails had always been on her bed. Review of resident 15's medical record revealed: *She had admitted on 3/23/15. *Her brief interview for mental status (BIMS) was 15 and indicated her cognition was intact. *She had a 6/23/21 physician order for a side rail to the upper outside of her bed to assist with bed mobility. *No documentation that education for risks and benefits of side rail use had taken place. *No signed informed consent from the resident or representative for side rail use. 2. Observation and interview on 11/17/21 at 3:41 p.m. with resident 29 revealed:	F 700	Facilities Director will educate Plant operations staff to complete regular safety checks on all side rails with intial installation and and then quarterly thereafter. These in-services will be completed by 12/22/21. DON or designee will complete 3 audits per week X 4, then 2 audits per month X 3 to ensure side rail requirements mentioned above are met to include safety checks. Results of the audits will be reported by the DON or designee and discussed at the bi-monthly QAPI meeting for further reivew 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 _____	11/18/2021

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 700	Continued From page 2 *He had bilateral side rails on the upper portion of his bed. *The outside rail was in the upright position. *The side rails assisted him to get in and out of bed. *The staff put the rails up and down for him because he could not move them. *He could not remember the staff educating him on the use of the side rails or signing an informed consent form for their use. *He was unsure when the side rails were put in place. Review of resident 29's medical record revealed: *He had admitted on 1/13/20. *His BIMS was 15 and indicated his cognition was intact. *His diagnosis of Parkinson's disease and Lewy body dementia. *He had a 9/13/21 physician order for side rails. *No documentation that education for risks and benefits of side rail use had taken place. *No signed informed consent from the resident or representative for side rail use. Surveyor: 44928 3. Observation and interview on 11/17/21 at 12:05 p.m. with certified nursing assistant (CNA) K while making resident 48's bed revealed: *A bed rail, in upright position, on the left side of the bed. *CNA K stated the resident used the side rail to reposition and get in and out of the bed. Review of resident 48's medical record revealed: *He was admitted on 2/4/20. *His BIMS was 5, indicating his cognition was moderately impaired. *His diagnosis included: acute head injury,	F 700		

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 _____	11/18/2021

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 700	Continued From page 3	F 700		

dementia with behavioral disturbance, multiple falls, and major depression.
*He had a restraint assessment completed on 8/23/21 that indicated the side rail was used for bed mobility.
*No documentation that education for risks and benefits of side rail use.
*No signed consent from the resident or representative for side rail use.

4. Observation and interview on 11/17/21 at 12:03 p.m. with CNA J regarding resident 27 revealed she:
*Had a side rail on the upper part of her bed which was in the upright potion, resident not in bed.
*CNA J stated, "she used it for repositioning."

Review of residents 27 medical record revealed:
*She had been admitted on 1/5/21.
*She was rarely understood, and BIMS could not be completed.
*Her diagnosis included: unspecified dementia with behavioral disturbances, anxiety disorder, and weakness.
*No documentation that education for risks and benefits of side rail use.
*No signed consent from the resident or representative for side rail use.

Surveyor: 45683
5. Observation on 11/16/21 at 10:01 a.m. of resident 28's room revealed a bedside pole next to his bed that extends from the floor to the ceiling.

Interview on 11/17/21 at 11:22 a.m. with resident 28 revealed:
*He does use the positioning pole to get in and

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 _____	11/18/2021

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 700	Continued From page 4	F 700		

out of bed.
*He does not recall getting any education on the risks and benefits of side rail use.

Review of resident 28's medical record revealed:
*He had been admitted on 7/6/21
*His BIMS score was 11 and indicated moderate cognitive impairment.
*His last revised care plan stated he may use grab bar on bed for bed mobility.
*No documentation that education for risks and benefits of side rail use had taken place.
*No signed informed consent from the resident or representative for side rail use.

6. Observation on 11/16/21 at 3:06 p.m. of resident 37's bed revealed a single side rail near the head of the bed in the upright position.

Review of resident 37's medical record revealed:
*He had admitted on 7/15/20.
*His BIMS score was 10 and indicated moderate cognitive impairment.
*An 8/10/21 physician order for a side rail to aid with bed mobility.
*A 10/18/21 restraint evaluation stated:
-The device was used to assist the resident to stand up.
-The question, "Can the individual easily remove the device?" was answered "not applicable it is on the bed, not the resident; he uses it to improve his independence."

Interview and observation on 11/17/21 at 10:46 a.m. with resident 37 revealed:
*He had not recalled getting any education on side rails.
*He relied on staff to put the side rail up and down.

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 _____	11/18/2021

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 700	Continued From page 5	F 700		

7. Interview on 11/17/21 at 9:30 a.m. with registered nurse (RN)/minimum data set (MDS) coordinator assistant H revealed:
*They had not:
-Provided education to the residents or their representatives on the risks and benefits of side rails.
-Requested informed consent from the resident or their representative.
-Performed regular safety assessments for the proper installation of side rails.

Interview on 11/17/21 at 10:06 a.m. with MDS Coordinator L revealed:
*They had not provided education to the resident or their representative on risks and benefits of side rails or obtained a signed informed consent form.
*They received a request from the therapy department or from the resident themselves for side rails.
*If the resident was cognitively appropriate they got a physicians order for side rail use.

Surveyor 41088:
Interview on 11/18/21 at 11:19 a.m. with administrator A and director of nursing (DON) B revealed:
*Side rail assessments for residents were completed with the quarterly minimum data set assessments.
*Were not aware of a side rail policy in place.
*They confirmed:
-Education to residents or their families had not taken place regarding the risks and benefits of side rail use.
-Consent forms had not been received from residents or their families for use of the side rails.

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 _____	11/18/2021

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 700	Continued From page 6 -They had not put the side rails on a schedule to be checked for safety and proper placement. On 11/18/21 at 11:42 a.m. DON B gave surveyor a copy of their facility policy for side rails. *She confirmed they had not followed their policy. 8. Review of the provider's revised September 2016 Safety Policy revealed: "Patient beds are equipped with: 1. Side rails only after the following criteria have been met: a. Upon the resident's admission or as the need is identified, staff assessment will determine if a bed equipped with side rails is necessary for mobility, and whether it is safe for that individual. b. The resident's care plan must document the need/use for side rails if the side rails are implemented. 2. Removable head boards [headboards]. 3. Mattresses and side rails are assessed so gap is no more than 4.75 inches. 4. Locking device to attain a secure stationary position. 5. Mechanism for adjustable positions."	F 700		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761	The facility does ensure proper medication disposal for all residents. All residents are potentially at risk. Resident 47 medications are unable to be reconciled because they have already been destroyed as resident is deceased.	1/11/22

Talli Raske

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 _____	11/18/2021

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 761	Continued From page 7 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, record review, and policy review, the provider failed to ensure medication disposal for one of two sampled residents closed record (47) had been completed by a registered nurse (RN) and a witness. Findings include: 1. Closed record review of resident 47's record revealed: *He had died on 9/29/21. *There was no documentation of what had been done with his medications. Interview on 11/18/21 at 10:58 a.m. with director of nursing (DON) B regarding medication destruction for deceased residents revealed their process was to: *Destroy controlled substance medications with one licensed nurse and the DON. *All other medications were sent back to the pharmacy for destruction. -This was to be documented in the resident's	F 761	DON will educate all RN and LPN staff to ensure all medications are accounted for and all medications are reconciled and documented in the medical record after discharge or death. The in-service will be completed by 12/22/21. DON or designee will perform audits on all residents that expire or are dicharged on the above requirement X 4 months. Results of the audits will be reported by the DON 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 _____	11/18/2021

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 761	Continued From page 8 electronic medical record [EMR]. -She could not find any documentation of the destruction of medications for resident 47. -She stated the pharmacy did not keep a record of what had been sent to them for destruction. Interview on 11/18/21 at 11:38 a.m. with assistant director of nursing E revealed she: *Had been unable to find any documentation of the destruction of medications for resident 47. -Stated their policy required this to be completed and they had not been doing it. Review of provider's 8/22 Medication Administration policy revealed: *"Purpose: 1. To ensure safe medication administration, and proper control, storage and accountability of medications within the facility." *"Policy" -"XX. Disposition of Outdated or Discontinued Medications". --"c. Outdated or discontinued medications (including medications that are left when a resident expires) are to be returned to Vilas pharmacy by placing them in a "return to pharmacy" tote in the 2nd floor/TCU (Transitional Care Unit) med [medication] room." --e. The nurse will document in the progress notes the name and dose of each medication followed by the number returned to the pharmacy." Review of provider's 3/20 Checklist for Nurses at time of Death of a Resident/Patient revealed: *"Medications need to be returned to pharmacy. A medication reconciliation progress note listing the medications returned should be placed in Meditech [EMR]."	F 761		

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 _____	11/18/2021

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 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	Directed Plan of Correction Avera Maryhouse F880 Corrective Action: 1. For the identification of lack of: *Appropriate cleaning and disinfection by housekeeping when cleaning resident care areas. *Appropriate cleaning and disinfection of glucose meters. *Appropriate hand hygiene by nurse during medication administration. *Appropriate cleaning and maintenance of cloth slings for use with mechanical lifts between multiple resident use. The Administrator, DON, Infection Control Nurse and/or designee in consultation with medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above care and services will be educated/ re-educated by 12/14/21 by DON and ADON.	12/15/21

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 _____	11/18/2021

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 880	Continued From page 10 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, manufacturer instructions, and policy review, the provider failed to ensure appropriate infection control precautions had been followed for: *One of one observation of housekeeper (M) while cleaning one of one resident (23) room. *One of one registered nurse (RN) (I) hand hygiene in two out of ten opportunities during medication pass. *One of one observation of glucometer use by	F 880	Identification of Others: 2. All residents and staff have the potential to be affected if staff do not adhere to identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and service tasks will be provided by 12/14/21 by DON and ADON. System Changes: 3. Root cause analysis conducted answered the 5 whys: Appropriate cleaning by housekeeping: employees were following protocol at the time, this is how they were trained to clean rooms with a sponge, Housekeeping Supervisor thought it was ok, acknowledged using a sponge from room to room was not a good practice and needed to change the procedure and re-train employee that a sponge can only be single room use and then thrown away.	

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 _____	11/18/2021

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 880	Continued From page 11 registered nurse (RN) G with a resident (42) on transmission based precautions. *One of one observation of certified nursing assistant (CNA) C and physical therapist (PT) D during transfer of one of one resident (14) during personal care. Findings include: 1. Observation and interview on 11/17/21 from 10:48 a.m. to 10:55 a.m. with housekeeper M cleaning resident 23's room revealed she: *Placed cleanser from a bottle into the bathroom sink using gloved hands. *Took a sponge out of her cleaning caddy, scrubbed the sink and rinsed it out. *Placed the sponge back into the caddy. *Placed liquid disinfectant solution onto the freestanding toilet riser and into the toilet bowl. *Continued cleaning with disinfectant wipes and wiped down the area above the sink, mirror and grab bar beside the toilet. *Took the toilet brush in both hands and squeezed out the excess liquid. *Leaned onto the sink with her left gloved hand while she cleaned the toilet and toilet riser. *Finished cleaning the toilet and toilet riser, and placed the toilet brush back into the caddy. *She confirmed: -She had not disinfected the sink after she touched it with her gloved hand. -Was not sure how long the wait time was for the disinfectant used. -Had not timed the wait time for the disinfectant. -She cleaned other things until she thought it had been long enough time to disinfect. -She should know the wait time of the chemical used. -She had been trained to use one sponge to clean all resident sinks and then toss it at the end	F 880	Appropriate cleaning and disinfection of glucose meters: There was a strip of paper taped to the glucometer making it uncleanable, Tape reminded staff to clean and use appropriate contact time with the disfinfectant, Didn't identify that the 3 minute contact time was not staying wet as it should on the device, After 5 whys identified we will change to 2 minute contact disinfectant wipe to ensure compliance of appropriate glucometer cleaning. Appropriate hand hygiene during medication administration: Unsure why RN didn't sanitize appropriately, RN didn't follow hand hygiene policy, RN thought she was doing it correctly, RN had not considered all of the potential contamination sources, education provided to bring awareness of all contamination sources not considered.	

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 _____	11/18/2021

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 880	Continued From page 12 of the shift. -At the start of the shift a new sponge is placed on her cart to use for the day. -Agreed it would be a better practice to use a clean cloth or sponge for each resident sink instead. Interview on 11/18/21 at 8:21 a.m. with housekeeping supervisor N revealed: *The sponges had a scrubbing surface on the other side for getting soap scum buildup off the sinks and that is why they were used. *She was aware the housekeepers used a clean sponge at the beginning of their shift and threw it away at the end of the day. *The sponge would be reused for all resident rooms for the day unless the resident was on contact precautions. *The housekeepers did not go into the resident rooms with COVID. -The nurses and CNAs cleaned those rooms unless a request was made for a more thorough cleaning by a housekeeper to avoid exposure. -If requested, the housekeepers used full protective personal equipment to go into those rooms. *She agreed reusing sponges between residents rooms could be an infection control concern and source of cross contamination. Review of the provider's revised July 2021 Environmental Services Cleaning Policy revealed: *"Carefully adhere to environmental cleaning guidelines. *Use and [sic] approved health care disinfectant, in concentrations established by housekeeping policies. *Strip room of linen items- take to the place where linen department collects items.	F 880	Appropriate cleaning and maintenance of cloth sings for use with mechanical lifts between multiple resident use: We had not identified that we should not be using these slings on multiple residents without cleaning in between, this was our process pre-pandemic, several residents did have their own sling but not all, We did not have enough slings for each resident to have their own, After completing the 5 why's methodology, ordered new slings to ensure each resident has their own sling. Administrator, DON, infection control nurse, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned tasks have received education/ training with demonstrated competency and documentation. Administrator contacted the SD Quality Improvement Organization (QIN) on 12/1/21. Discussed and reviewed F Tag 880 and the 4 examples cited in the 2567 report, reviewed the 5 why's methodology for route cause analysis, discussed our facility is already working with the QIN as a CMS referred Covid Hotspot due to 3 resident positives. We had developed a 6 week quality improvement plan that	

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 _____	11/18/2021

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 880	Continued From page 13 *Provide special attention to decontamination of frequently-touched surfaces [e.g. over-bed tables, bed-rails, remote control, call buttons, telephones, lavatory surfaces, commodes, ventilators, over-bed bars, etc.]. *Disinfectant solutions for rags/mops should be discarded after use. *Mops and rags may be routinely laundered, using the health care facility's laundry. *Keep the environment around the patient free of unnecessary supplies and equipment to minimize contamination. *Infection control will advise staff of additional or different protocol." Surveyor: 44928 2. Observation on 11/17/21 at 10:00 a.m. of RN I during medication pass revealed she had missed two out of ten opportunities to perform hand hygiene between residents. Interview on 11/18/21 at 9:21 a.m. with director of nursing (DON) B regarding the above observations revealed she had expected all staff to perform hand hygiene after administering medications to a resident and before moving on to the next resident. Review of the provider's revised October 2021 Hand Hygiene policy revealed: *"Hand hygiene (HH) continues to be the primary means of preventing the transmission of infection." *"A. HH, either with soap and water or with alcohol-based hand rub (ABHR)[.] -1. Immediately before touching a resident[.]" -"4. After touching a resident or the resident's immediate environment[.]"	F 880	includes auditing 4 different areas identified when completing a root cause analysis regarding infection control. QIN shared some infection and prevention tools and resources. Monitoring: Administrator, DON, Infection control nurse, and/or designee will conduct auditing and Monitoring for areas identified above. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2-3 times weekly for 4 weeks, Administrator, DON, infection control nurse, and/or a designee making observations across all shifts to ensure staff compliance with: *Staff compliance in the above identified area *Any other areas identified through the Root Cause Analysis After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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 _____	11/18/2021

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 880	Continued From page 14 Surveyor: 43844 3. Observation on 11/17/21 at 12:50 p.m. revealed a Stat Strip (blood glucose monitoring machine): *Had been laying on paper towel, on canister of disinfectant wipes, in the hall by resident 42s room: *There had been a strip of paper taped on the top of the machine that stated, "clean after each use (3 min wet time)". -This strip of taped paper was peeled back approximately one inch from left edge of the glucometer. --This peeled taped had exposed paper underneath, making it an uncleanable surface. Interview on 11/17/21 at 1:08 p.m. with RN G revealed: *She had used the glucometer to test the blood sugar of resident 42, who was on transmission based precautions. -She had attempted to clean the glucometer by using a disinfectant wipe. *She had placed the glucometer on a docking station at the nurses desk. *The glucometer was shared with residents, needing their blood sugar checked, on the same wing as resident 42. Interview and observation on 11/17/21 at 4:21 p.m. with DON B regarding glucometer cleaning revealed: *They had utilized hospital grade glucometers. -The glucometers were placed on a docking station after use. --The information from the glucometer would be downloaded from the docking station into the resident's electronic medical record. -Each floor had one glucometer.	F 880		

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 _____	11/18/2021

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 880	Continued From page 15 *Glucometers had been shared between residents. -They had been disinfected between residents using them. -They had provided training to staff. Observation on 11/17/21 at 4:26 p.m. with DON B and RN F revealed: *The glucometer had been on the medication cart. *DON B and RN F agreed there was taped paper that had been peeling off the glucometer on one side. -DON B agreed this had made the glucometer a non-cleanable surface. -RN F removed the peeling taped paper. --She had not realized it had been on the glucometer. ---Agreed it should not have been on the glucometer. Surveyor: 45095 4. Observation and interview on 11/16/21 at 4:34 p.m. with CNA C and PT D while assisting resident 14 revealed: *Resident was assisted onto the toilet with the mechanical lift. *CNA reported the facility did not have enough slings for every resident to have their own. *Staff shared cloth slings between the residents. *CNA explained staff had been wiping the harnesses down with sanitizer wipes. -She demonstrated cleaning the mechanical lift and harness by wiping them down with Kimtech Wettask System wipes. *CNA reported residents on transmission based precautions had their own harness. Interview on 11/18/21 at 10:00 a.m. with DON B	F 880		

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 _____	11/18/2021

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 880	Continued From page 16	F 880		

revealed:
*A new mechanical lift with additional harnesses had been ordered.
*There had been conversations regarding if residents should each have their own harness.
*Residents on transmission based precautions had their own harness.
*Cleaning with the Kimtech Wettask System wipes would not disinfect the harness as they are cloth.
*Harnesses had been shared amongst residents, the facility did not have enough harnesses for each resident to have their own.
*She agreed harnesses should not have been shared amongst residents.

Review of the EZ Way, Inc. manufacturer instructions for washable slings and harnesses revealed:
*"Washable EZ Sling and Harness Laundering instructions
-To get the longest life out of your product:
--1. Do not bleach
--2. To prevent stains from setting, rinse 5 min. in 80-100 degree F. Stains will set when temp is over 105 degrees F.
--3. Wash temp 160 degrees F. max.
--4. RINSE THOROUGHLY in 100 degree F. If high alkaline detergent (with pH greater than 11.0) is used, rinse twice.
--5. Tumble dry, temp. 110 degrees F. max. high heat will weaken the fabric.
--6. If applicable, snap the buckle together before washing and drying. this will prevent any damage to the plastic buckle.
--7. If available, use a laundry bag to wash and dry the sling or harness."
*Manufacturer instructions did not include the use of disinfectant wipes.

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 _____	11/18/2021

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 880	Continued From page 17 5. Review of the provider's July 2021 Avera LTC - Disinfection of Non-Critical Patient Care Equipment policy revealed: *"I. PURPOSE -A. Cleaning, disinfecting and storing equipment and supplies is important in preventing the transmission of potential pathogens within the long-term care facility. -B. In order to more easily control quality, cleaning, disinfection, and sterilization of re-usable patient care equipment, whenever possible, "critical and semicritical" disinfection will be completed by a facility in which sterilization practices are provided. Processes for handling and transport of equipment are designated by the receiving site. Sterile single use equipment will be utilized when appropriate. -C. For the safety and comfort of residents, all reusable("non-critical") resident care items will be cleaned, disinfected, and maintained in a safe manner between resident uses." *"II. INFORMATION -A. Reusable resident care equipment/items fall into 3 different classification categories for disinfection and sterilization: "non-critical, semi-critical, and critical. --1. "Non-Critical" items are those that come into contact with intact skin but not mucous membranes. these are divided into resident care items and environmental surfaces. ---a. Non-critical resident care items (Examples include blood pressure cuffs, stethoscopes, wheelchairs, therapy equipment) are cleaned between/after each resident use. They require Low level disinfection by cleaning following manufacturer instructions with an EPA-registered disinfectant, detergent, or germicide that is approved for healthcare settings."	F 880		

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 _____	11/18/2021

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 880	Continued From page 18 ---"3. "Critical" items (Examples include needles, intravenous catheters, indwelling urinary catheter) enter sterile tissue or the vascular system. These items or equipment must be sterile when used, based on one of several accepted sterilization procedures. Most items in this category for LTC [long term care] are purchased sterile." -"D. Non-critical items rarely, if ever, transmit disease but could contribute to secondary transmission by contaminating HCW (health care worker) hands or by contact with medical equipment that will subsequently come in contact with patients. Consequently, cleaning with a facility approved disinfectant is sufficient." *"III. POLICY -A. Community/facility items removed from a resident's room need to be disinfected prior to use by a different resident." -"E. All reusable resident care equipment removed from a resident room/procedure room is disinfected before use on another resident." -"K. Disinfection recommendations- 1. Reusable resident care equipment: All applicable label instructions on EPA-registered [Environmental Protection Agency] disinfectant products must be followed. (Examples are use-dilution, shelf life, storage, material compatibility, safe use and disposal.) -a. Between each resident use and when soiled" -"e. Glucometer or re-useable point of care testing labeled for multiple resident"[.]	F 880		

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 _____	11/18/2021

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 Surveyor: 41895 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 11/16/21 through 11/18/21. Avera Maryhouse Long Term Care was found in compliance.	E 000		

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

Talli Raske | Administrator | 12/9/21

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.

DEC 09 2021

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 **01 - MAIN BUILDING 01** B. WING _____	**11/16/2021**

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 Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/16/21. 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 11/18/21. 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 deficiencies identified at K321 and 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:	K 226		F

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

TITLE
Administrator

(X6) DATE
12/9/21

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 _____	**11/16/2021**

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 Surveyor: 40506 Based on observation, testing, interview, and 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 11/16/21 at 1:30 p.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 opened 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 8/7/19 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		

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 **01 - MAIN BUILDING 01** B. WING _____	**11/16/2021**

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 321 SS=E	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. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A 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) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain a hazardous areas (storage room) on the third floor as required. Findings include:	K 321	An Extension waiver request was submitted to DOH Life Safety on 12/8/21. Request for waiver was due to needing to order a new door and frame to correct this deficiency. Time frame of delivery is unknown due to delayed shipment with the pandemic. Extension waiver request was granted for the new door installation. Door and frame will be installed on or before 5/16/22.	5/16/22

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 _____	**11/16/2021**

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 321	Continued From page 3 1. Observation on 11/16/21 at 2:15 p.m. revealed the room originally designated as a bathing room on the third floor of building one was being used as a storage room. It occupied more than 100 square feet, and contained eight wheelchairs, three commodes, and four plastic storage cabinets holding approximately 48 cubic feet of combustible storage. The door to the room had no closer, and the frame was equipped with a mechanism to allow the door to swing in either direction. There was no latch available. The deficiency affected two of numerous requirements in place for hazardous storage rooms. Interview with the supervisor and director of facilities confirmed that they were aware of the storage, but had attempted to keep it all non-combustible storage. Because of the age of the building, storage space was limited.	K 321		
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:	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 to have more practice and ensure staff have knowledge of procedures. Administrator and DON will educate all staff on the facilitiy's fire drill procedures. This in-service will be completed by 12/22/21. The Administrator or designee will complete audits weekly X 6 weeks, then monthly X 3 to ensure fire drill procedures are meeting all requirements.	1/11/22

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 **01 - MAIN BUILDING 01** B. WING _____	**11/16/2021**

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 Surveyor: 40506 Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to a smoke protected area, closing corridor doors and checking the door for the fire location). Findings include: 1. Observation on 11/16/21 at 4:15 p.m. revealed the nurse call was initiated by the maintenance supervisor. Staff responded quickly, was told a fire drill had been initiated. Staff person removed resident from the room, but did not close the door after resident removal. Staff used her hand-held device to request an overhead page. The request was either not heard, or not acted on. Staff then dropped off the resident in a sitting area within the same smoke compartment where resident was left with two other residents until the administrator reminded staff that all residents needed to be in a separate smoke compartment. Although fire extinguishers were brought to the area, no staff attempted to put out the "fire". No staff checked the door or the space to see if it was safe to attempt to put out the fire with an extinguisher. Interview with the maintenance supervisor and facilities director at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants.	K 712	Results of 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.	

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 _____	**11/16/2021**

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 Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/16/21. 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 11/18/21. 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 deficiencies 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:	K 226		F

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

TITLE: Administrator

(X6) DATE: 12/9/21

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 **02 - BUILDING 02** B. WING _____	**11/16/2021**

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 Surveyor: 40506 Based on observation, testing, interview, and 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 11/16/21 at 1:30 p.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 opened 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 8/7/19 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		

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 _____	**11/16/2021**

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	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. This REQUIREMENT is not met as evidenced by: Surveyor: 40506 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 11/16/19 at 10:30 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	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 _____	**11/16/2021**

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 3 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 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: Surveyor: 40506 Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to a smoke protected area, closing corridor doors and checking the door for the fire location). Findings include: 1. Observation on 11/16/21 at 4:15 p.m. revealed the nurse call was initiated by the maintenance supervisor. Staff responded quickly, was told a fire drill had been initiated. Staff person removed resident from the room, but did not close the door after resident removal. Staff used her hand-held device to request an overhead page. The request was either not heard, or not acted on. Staff then dropped off the resident in a sitting area within the same smoke compartment where the resident was left with two other residents until the	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 to have more practice and ensure staff have knowledge of procedures. Administrator and DON will educate all staff on the facility's fire drill procedures. This in-service will be completed by 12/22/21. The Administrator or designee will complete audits weekly X 6 weeks, then monthly X 3 to ensure fire drill procedures are meeting all requirements. 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.	1/11/22

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 _____	**11/16/2021**

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 administrator reminded staff that all residents needed to be in a separate smoke compartment. Although fire extinguishers were brought to the area, no staff attempted to put out the "fire". No staff checked the door or the space to see if it was safe to attempt to put out the fire with an extinguisher. Interview with the maintenance supervisor and facilities director at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants.	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 _____	**11/16/2021**

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 Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/16/21. 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 11/18/21. 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 deficiencies identified at K300 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 300 SS=E	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 300	An extension waiver request was submitted to DOH Life Safety on 12/8/21. Request for waiver was due to needing to order new doors and frames to correct this deficiency. The time frame of delivery is unknown due to delayed shipment with the pandemic. Exntension waiver request was granted for the new door installation. Doors and frame will be installed on or before 5/16/22.	5/16/22

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

Talli Raske

TITLE: Administrator

(X6) DATE: 12/9/21

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 **03 - BUILDING 03** B. WING _____	**11/16/2021**

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 300	Continued From page 1 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain two separate two-hour walls in the lower level as required. Findings include: 1. Observation at 11:45 a.m. on 11/16/21 revealed * There was a crack above the frame the width of the frame that extended from the nursing home occupancy to the hospital occupancy. Hence, there was no smoke or fire separation. * The door frame thickness was not adequate to provide the required width for a two-hour separation, therefore, the wall thickness was not a two-hour separation. 2. Observation on 11/16/21 at 1:40 p.m. revealed the door and wall separating the lobby at door three and the corridor was not a two-hour separation. There was a crack above the frame the width of the frame that extended through the wall. Hence, there was no smoke or fire separation. Interview with the maintenance supervisor and the facility director at the times of the observations confirmed those findings. The deficiency affected two of numerous requirements for occupancy separations.	K 300		
K 311 SS=C	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation	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 **03 - BUILDING 03** B. WING _____	**11/16/2021**

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 2 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: Surveyor: 40506 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 11/16/21 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 5/15/18 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	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 **03 - BUILDING 03** B. WING _____	**11/16/2021**

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 3 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 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: Surveyor: 40506 Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to a smoke protected area, closing corridor doors and checking the door for the fire location). Findings include: 1. Observation on 11/16/21 at 4:15 p.m. revealed the nurse call was initiated by the maintenance supervisor. Staff responded quickly, was told a fire drill had been initiated. Staff person removed resident from the room, but did not close the door after resident removal. Staff used her hand-held device to request an overhead page. The request was either not heard, or not acted on. Staff then dropped off the resident in a sitting area within the	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 to have more practice and ensure staff are aware of proper procedures Administrator and DON will educate all staff on the facility's fire drill procedures. This in-service will be completed by 12/22/21. The Administrator or designee will complete audits weekly X 6 weeks, then monthly X 3 to ensure fire drill procedures are meeting all requirements. 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.	1/11/22

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 _____	**11/16/2021**

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 same smoke compartment where the resident was left with two other residents until the administrator reminded staff that all residents needed to be in a separate smoke compartment. Although fire extinguishers were brought to the area, no staff attempted to put out the "fire". No staff checked the door or the space to see if it was safe to attempt to put out the fire with an extinguisher. Interview with the maintenance supervisor and facilities director at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants.	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 _____	11/18/2021

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 Surveyor: 41895 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/16/21 through 11/18/21. Avera Maryhouse Long Term Care was found not in compliance with the following requirements: S157 and S253.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in three randomly observed rooms in Building 1, first floor (janitor's closet, soiled utility, and resident room 101). Findings include: 1. Observation on 11/16/21 at 10:40 a.m. revealed the exhaust ventilation for rooms on the first floor (janitor's closet, soiled utility, and resident room 101) did not have working exhaust. All three were immediately adjacent, and only tested to be certain that the system was down throughout. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Interview with the maintenance supervisor and facility director at the time of testing on 11/16/21 confirmed that finding. They revealed they were unaware as to why the exhaust ventilation was	S 157	The facility does maintain exhaust ventilation for all areas. All residents are potentially at risk. The first floor janitor's closet, soiled utility room and resident room 101 exhaust ventilation all have been corrected. The Facilities Director will educate the Maryhouse plant Operations employees to inspect the exhaust ventilation system weekly in the facility to ensure proper working condition. The in-service will be completed by 12/22/21. The Administrator or desginee will complete audits to ensure the exhaust ventilation system is working properly. Random audits will be completed 3 weekly X 4, then 3 monthly X 3. 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.	1/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Talli Raske | TITLE: Administrator | (X6) DATE: 12/08/21

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 _____	11/18/2021

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 157	Continued From page 1 not working at these locations.	S 157		
S 253	44:73:04:14 Memory Care Units Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family; (5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety Code, 2012 edition; and (6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to obtain physicians' orders for four of four sampled residents (15, 28, 29, and 37) residing in the	S 253	The facility does ensure to obtain physician orders for all residents residing on the secure unit on 3rd floor. All residents are potentially at risk. Residents 15, 28, 29, and 37 were reviewed for the above requirement and are now compliant. DON will educate the care plan team and all RN and LPN staff on the requirement to obtain physician orders for all residents residing on the secure unit on 3rd floor by 12/22/2021. DON or designee will perform 2 audits per week x 4 and then 2 audits per month x3 on residents that reside on 3rd floor to ensure there is a physician order in place to reside on 3rd floor secure unit. Results of the audits will be reported by the DON and discussed at the bi-monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits.	1/11/22

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 _____	11/18/2021

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 253	Continued From page 2 secured unit. Findings include: 1. Random observations on 11/16/21 from 8:00 a.m. to 6:00 p.m., on 11/17/21 from 7:30 a.m. to 6:00 p.m., and on 11/18/21 from 7:30 a.m. to 1:15 p.m. revealed residents 15, 28, 29, and 37 had resided in the secured unit of the facility. Interview on 11/17/21 at 3:26 p.m. with certified nursing assistant (CNA)/activity assistant O revealed: *If the resident had no memory issues they could usually get a key for the elevator. *She thought there were only two residents (36 and 40) that had keys to the elevator. *If any other resident wanted to leave the unit or use the stairs they had to ask staff. Interview on 11/17/21 at 3:41 p.m. with resident 29 revealed: *Sometimes there were residents waiting by the elevator for 30 minutes for staff to come and open the elevator. *He would rather not have to wait for staff to leave the unit. Review of resident 15, 28, 29, and 37's medical records revealed: *No physician's orders for placement in the secured unit including medical justification for placement. *The above residents had elopement risk assessments completed that stated they were not at risk for elopement. Interview on 11/17/21 at 3:53 p.m. with administrator A and director of nursing B revealed: *All residents were assessed on admission for	S 253		

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 _____	11/18/2021

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 253	Continued From page 3 their needs. *If there had been a concern an elopement assessment was completed. *Recently they had closed one floor of the facility to accommodate for staffing issues. *Some residents had been moved to the secured unit as a result. *The unit required a key to use the elevator and a code to access the exit doors. *They were aware of two residents on that unit who had keys to the elevator. *They had not heard of concerns from residents about access off the unit. *They confirmed residents would have to wait for a staff to exit unless they had a key or knew the code. *They had not obtained physician orders with rationale for residents to be on the secured unit and were not aware it was needed. Review of the provider's revised June 2017 admission packet Safety Information revealed: "[Facility name] strives to use the least restrictive physical and chemical measure available."	S 253		
S 000	Compliance/Noncompliance Statement Surveyor: 45095 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 11/16/21 through 11/18/21. Avera Maryhouse Long Term Care was found in compliance.	S 000		