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
	435042	A. BUILDING _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/21/23 through 3/23/23. Avera Mother Joseph Manor Retirement Community was found in not in compliance with the following requirements: F554, F684, F686, F812, F849, and F880.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure: *One of one sampled resident's (10) medication had been labeled and securely stored. *Proper medication self-administration practices had been followed for one of one sampled resident (10). Findings include: 1. Observation and interview on 3/21/23 at 3:41 p.m. with resident 10 in her room revealed: *There was a clear plastic container with a screw-top lid sitting on her overbed table. -There were five or six white circular pills in the container. -The container was not labeled with any information. *When asked what the pills were for, resident 10 responded, "It's for my stomach cramps. I can take one every four hours."	F 554	Self -Administration with the Bedside Medication Policy will be reviewed and/or revised by 4/21/23. Nursing and Medication Aide staff will be educated / re-educated on the Self-Administration policy by the Staff Development Coordinator or designee by 4/21/23. Resident Care Coordinator (RCC) or designee will complete a Self-Administration of Medication Evaluation on Resident (10). Order will be obtained from Physician, education will be provided to the Resident, Lock box provided, medication will be properly labeled, and return demonstration will be completed by Resident. Nursing staff will monitor for Medication side effects, adverse reactions and provide ongoing education. The Resident will document medications taken on Medication Administration Record with each dose. The Nurse will reconcile the medication number with documentation on each shift. Residents care plan will be individualized to meet resident's self-administration needs. The care plan and self-administration of medications at bedside will be evaluated quarterly and/or with any change of status by 4/21/23.	4/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Snyder
TITLE: Administrator
(X6) DATE: 4/20/2023 with Addendums

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

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F 554	Continued From page 1 2. Interview on 3/22/23 at 10:01 a.m. with registered nurse (RN) U regarding resident 10's medication revealed: *The medication on her overbed table was simethicone. *Resident 10 was able to self-administer her simethicone after set-up assistance. *To set-up the medication for her, they would pop the pills out of the prescription card, put the pills in the plastic container, and place the container on her overbed table when resident 10 asked for more of the pills. 3. Interview on 3/22/23 at 10:06 a.m. with resident care supervisor (RCS) D regarding resident 10's medication revealed: *Mediation self-administration would have been documented under the activities of daily living section of the resident's care plan. *They would have reassessed the resident's ability to self-administer medications at least quarterly with each Minimum Data Set (MDS) assessment. *Resident 10's care plan did not include a description of the medication that was self-administered. *Resident 10 had been living at the facility for several years, and the medication self-administration physician's order was from her admission in 2017. 4. Interview on 3/22/23 at 4:33 p.m. with assistant director of nursing (ADON) C about resident 10's medication revealed: *Resident 10 was visually impaired. *She liked to keep things in the same spot so she could find them. *She had increased anxiety when she was first admitted in 2017 because she could not have her	F 554	All current Residents care planned to self-administer of bedside medications will be reassessed for self-administration and compliance per the Self-Administration of Medications Policy by RCC or designee by 4/21/23. Monthly audits will be completed by RCC or designee to demonstrate expectations are being met. Audits will continue for a total of 6 months. Results from the audit will be reported by RCC or designee to QAPI Committee and continue until the facility demonstrates sustained compliance as determined by the QAPI Committee.	

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F 554	Continued From page 2 medications at her bedside. -At that time, they assessed her for medication self-administration. *She indicated her staff "probably should have labeled the medication." *She confirmed: -To set-up the medication for resident 10, staff would pop the pills out of the prescription card and put them in the clear plastic container. -They did not have a secure location to keep her medication due to her vision impairment. *There could have been a risk of a resident wandering into her room and mistakenly taking the medication. At that time, policies for medication self-administration, medication labeling, and medication storage were requested. The requested information had not been provided by the end of the survey on 3/23/23 at 1:10 p.m. 5. Interview on 3/22/23 at 5:05 p.m. with RCS D and RCS E regarding resident 10's medication revealed: *They had physician orders to set-up her medication to self-administer. *They would give her six simethicone pills at a time, and she took them on an as-needed (PRN) basis. *The PRN medication was not labeled once placed in the clear plastic container. *They confirmed there could have been a risk of a resident wandering into her room and mistakenly taking the medication. At that time, policies for medication self-administration, medication labeling, and medication storage were requested again. The requested information had not been provided by	F 554		

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F 554	Continued From page 3 the end of the survey on 3/23/23 at 1:10 p.m. 6. Review of resident 10's list of "active medications" revealed: *There was a physician's order for "Simethicone 80 Mg [milligrams] Chew." -The medication route was "PO [by mouth]." -The frequency was "Q4H PRN [every four hours as needed]." -The reason was "Flatulence." -The physician order started on 8/1/22. -The order had not indicated that she could self-administer the medication after set-up assistance. 7. Review of resident 10's care plan revealed that there was no documentation of her medication self-administration status. 8. Review of resident 10's 3/7/23 quarterly MDS assessment revealed she had a Brief Interview for Mental Status score of 12, indicative of moderate cognitive impairment. 9. Review of resident 10's physician's admission order sheet from 10/9/17 revealed: *The primary medical diagnosis was "dementia - [history] of brain tumor - seizure activity." *The secondary medical diagnoses were: "[hypertension] - anemia - [chronic kidney disease] - [extended-spectrum beta-lactamases] in urine - macular degeneration - [carbapenem-resistant Enterobacterales]." *Under the "Basic Treatments" section, the line item "May self administer meds after set up by the nurse," was checked. 10. Review of resident 10's "Self Administration LTC" assessment from 10/17/17 revealed:	F 554		

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F 554	Continued From page 4 *Under the "Approval Not Granted" section: -"Resident does have poor vision ... She will have her ... Gas X Chew [simethicone] at bedside in her room per [provider's order] on 10/17/17. This will be reviewed with her [primary care provider] on 10/19/17 on rounds. Resident has situational distress with changes in her living arrangements and inability to have these medications at bedside upon admission. Will monitor use and safety and [discontinue] if she is unsafe with it." *The physician was notified and approved the resident self-administering her medication. 11. Review of resident 10's "Self Administration LTC" assessment from 6/29/20 revealed: *At the time of the assessment, she was able to: -State the reason for the medication. -"Read label or identify medication." -State the time medications should have been taken. -Correctly state and demonstrate the proper dosage for each medication. -Open and close the medication containers. -Demonstrate secure storage for medication in room. -Correctly request medication. -"Understand and will not leave medication unattended." -Recognize the quantity of medication to take at a given time. *Under the "Approval Not Granted" section: -"Resident continues to be able to identify her bedside meds when staff ask her. She does have poor vision, but has adapted to the feel of her medication containers and is able to see well enough to identify them and use them correctly." 12. Policies for policies for medication self-administration, medication labeling, and	F 554		

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F 554	Continued From page 5 medication storage were requested on 3/22/23 at 4:33 p.m. from ADON C, and again on 3/22/23 at 5:05 p.m. from RCS D and RCS E. The requested information had not been provided by the end of the survey on 3/23/23 at 1:10 p.m.	F 554		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Ensure environmental precautions were in place to prevent harm to one of one sampled resident (37) who received a burn to her left ankle from a heat register in her room after her bed had been moved. *Implement timely and appropriate bowel management interventions for one of one sampled resident (128) who had been receiving hospice services. Findings include: 1. Observation on 3/21/23 at 8:09 a.m. and again at 10:08 a.m. of resident 37 revealed: *She was lying in bed under the blankets and appeared to be sleeping soundly. *The bed was in the lowest position and a fall mat was on the floor in front of the bed.	F 684	Bowel protocol Policy will be reviewed and revised by DON or designee to meet the Quality-of-Care requirement in regard to Resident bowel management while on Hospice Services by 4/21/2023. Hospice Services and all Nursing Staff will be educated / re-educated on Bowel Protocol by the DON or designee by 4/21/2023. To collaborate with Avera Mother Joseph Manner, Hospice Services will place a green binder on each Nursing Neighborhood. Within the green binder will be a different tab for each hospice patient in that neighborhood. It will also be divided out into the service line categories of Nurse, Aide, Social Work, Chaplain and POC. At each Hospice visit, the hospice staff will chart in the Meditech \ Homecare, print off their document and place it in the appropriate slot in the green binder, this will be implemented by Hospice services or designee by 4/21/2023. The only exception to this will be the initial nurse admit documentation, which will be expected to be finished within 24 hours of admit and faxed to Avera Mother Joseph Manor with attention to the Resident Care Coordinator and / or current Charge Nurse. Hospice Services or designee will audit the above collaboration for compliance monthly, for a total of 6 months.	4/21/2023

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F 684	Continued From page 6 *She had a full body pillow positioned beside her on the non-wall side. *A call button was clipped to the pillow at the head of her bed. *There was a wheelchair in the corner of her room with a Pommel cushion setting in it. *At 10:08 a.m., she was lying on top of her made bed, dressed and groomed under a throw blanket and appeared to be sleeping soundly. Review of resident 37's medical record revealed: *She was admitted on 10/11/22. *Her Brief Interview for Mental Status (BIMS) score was 12 indicating her cognition was mildly impaired. *Diagnoses included Parkinson's disease, dementia, repeated falls, a burn, pain, limited range of motion, history cerebral infarction, dysphagia, weight loss, and adult failure to thrive. *On 3/3/22 the Wound/Incision -Complex assessment documented an open pink wound measuring 3.5 centimeters (cm) length x 2.5 cm width x 0.1 cm depth with an 8.75 cm wound area. An Optifoam dressing was placed over the wound/burn. *On 3/10/23 the Wound/Incision-Complex assessment documented the burn to the left ankle was 5 cm length x 5.3 cm width x 0.1 cm depth with a wound area 26.5 cm and described as redness surrounding the wound, It had a white open area inside the wound, a fluid-filled blister at the distal end of the wound and a purple area in the center of the wound. *On 3/18/23 the Wound/Incision - Complex assessment documented the burn to left ankle was 4 cm length x 2.5 width, 10 cm wound area with a dark area in center over the ankle bone and a 6 cm x 5 cm red macerated [occurs when skin is in contact with moisture for too long] area	F 684	Audit results will be reported by Hospice Services or designee to the QAPI Committee Quarterly until the facility demonstrates sustained compliance as determined by QAPI Committee. Policy Safe Resident Environment and Movement will be review and revised by DON or designee to ensure that environmental precautions are in place to prevent harm to a Resident by 4/21/2023. Addendum: Changes made in a Residents room will be communicated by DON or designee to staff by email, written in communication book kept at the Nurses Station, discussed in Shift-to-Shift report/daily line-up, by policy review and Care planned when/if needed. 4/20/23 All facility staff who are involved in, or responsible for assuring a Residents Safe Environment will be educated / re-educated on Policy Safe Resident Environment and Movement by 04/21/2023. All currently occupied resident rooms and new admission rooms will be assessed and evaluated by the DON or designee to assure a safe environment ie: bed not placed against a heat register by 4/21/2023. DON or designee will continue monthly audits to assure the Safe Resident Environment and Movement policy is in compliance for 6 months. Results from the audit will be reported by the DON or designee to QAPI Committee and continue until the facility demonstrated sustained compliance as determined by the QAPI Committee.	

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F 684	Continued From page 7 surrounding open area. *On 3/15/23 [Avera St. Luke's] wound care clinic orders were written as "Burn L [left] foot dressing change every three days. 1.) Exoderm/Duoderm to burn site 2.) upon change clean with sterile water, dry well. 3.) Allow any necrotic tissue to peel away. 4.) f/u [follow up] 2 weeks. Ensure bottle x 1 a day. Next appointment on 3/29/23 9:30 am." *There was no documentation in the resident's medical record indicating what type or degree of burn the resident had. Review of resident 37's comprehensive care plan initiated on 10/11/23 and revised through 3/10/23 revealed: *"Problem -Skin Integrity --"As evidenced by: urinary incontinence, Braden reveals mild risk, requires extensive assistance with bed mobility & toileting" ---"3-6-23 left outer ankle as a large pink area. Optifoam gentle to left outer ankle-change every 5 days until healed." ---"3-10-23 left outer ankle has clear liquid drainage on dressing, odor when taking dressing off, area is worse than on 3-6-23. (see measurements). will update MD to get wound consult". -"Nutritional Status --Severely compromised nutrition status D/T [due to]: significant weight loss and needs altered diet texture and staff assistance. ---Meals at assisted table. ---Supplement with noon & supper meals and prn [as needed] Try hot chocolate Boost at breakfast." ---"Black enlarged handled silverware and divided plate."	F 684		

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F 684	Continued From page 8 -"Fall risk --As evidenced by history of falls, impaired balance, Psychotropic drugs, Impaired cognition secondary to Parkinson and dementia." ---"1/26/23 pommel cushion in wheelchair per safety huddle and therapy review is to continue restorative therapy and check on resident frequently." Review of the provider incident report dated 3/3/23 revealed: *Resident's injury was due to her left ankle resting against the heat register in her room. *Her room had been rearranged and the bed was moved along the wall next to the heat register. *Once the burn was identified and addressed by staff her bed was moved away from the heat register on the wall. *Education was provided to the staff that before rearranging resident's rooms they were to consult with the resident care coordinator for permission, an email was sent to the staff and the education was reinforced during the staff daily line-up meetings. *The physician and family were notified of the incident. Observation and interview on 3/22/23 at 9:22 a.m. with licensed practical nurse (LPN) Q during the wound care for resident (37) revealed: *The wound was a burn on her left ankle and was a result of her ankle resting on the heat register on the wall while she was lying in bed. *The bed was now moved away from the heat register and was placed against a different wall. *The resident required staff assistance for transfers and repositioning. *Skin assessments of identified wounds were completed on Saturdays and Sundays by staff	F 684		

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F 684	Continued From page 9 nurses with measurements completed at that time. *The provider did not have a designated wound care nurse. *If residents wounds were not improving or worsened they were referred to the wound care clinic. *She had no formal wound care training. *The resident had been referred to the wound care clinic after her burn wound had worsened. *The old dressing was removed, the area was cleansed with normal saline, patted dry with gauze and a Exoderm dressing was placed over the residents' burn wound. *The left ankle burn was approximately 4 cm length x 2.5 width, it had a dark black area in the center over the ankle bone and had approximately a 6 cm x 5 cm red macerated area surrounding the dark area in the center of the burn. *The resident moaned, cried out and attempted to move her foot away from the nurse during the wound care process. *LPN Q agreed she was exhibiting behaviors of pain and stated that had been her usual response during the wound care for her burn. *LPN Q stated the resident was able to communicate by answering questions with a yes or no, it took her a while to respond and it was a very soft and quiet whisper when she would speak. *No resident verbal communication was observed during the observations. *The staff had received an emall that there was to have been no rearranging resident's furniture in their rooms without the permission from the resident care coordinators. Interview on 3/23/23 at 8:59 a.m. with assistant	F 684		

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F 684	Continued From page 10 director of nursing (ADON) C revealed: *Initially resident rooms were arranged per the resident's choice, their needs, and in resident 37's case she was dominant on one side so they would have looked at what was going to work best for her. *Rearranging furniture in resident's rooms was not something that happened in the facility. *Staff had historically not taken it upon themselves to rearrange furniture and that event was a total fluke. *Administrative staff had a meeting and completed the 5 why's. *Staff that had worked that shift were interviewed and two days prior to the identification of the resident's burn was when they had thought the residents bed had been moved. *No staff had come forward or admitted moving the bed and no staff had knowledge of why the bed had been moved. *The provider does not have a designated wound care nurse. *The charge nurse completed the wound care and would send a fax to the physician for communication and to obtain orders. *Nurses had not received any specialized training for burn wound care. *Resident care coordinators would have been consulted if a wound was not healing, they had assigned on line training for wound care along with each staff nurse. *The provider utilized outside referrals to consult for wound care at the hospital with a physician order. *She felt the nursing staff had the education to have known when to reach out for wound care consults with regards to wound changes or decline in the wound status.	F 684		

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F 684	Continued From page 11 Interview on 3/23/23 at 9:49 a.m. with registered nurse (RN) P while performing another task revealed: *There was no designated wound care nurse. *The charge nurse was responsible for resident's wound care during their scheduled shift. *Nurses and CNAs completed on-line training and she had not received any specialized wound care training. *If a resident's wound was not improving or worsening the charge nurse would fax the physician and get an order to send the resident to the wound care clinic. *The staff had received an email regarding there was to have been no rearranging resident's furniture in their rooms without permission from the resident care coordinators. Interviews on 3/23/23 between 10:35 a.m. and 11:20 a.m. with CNAs S, R and J revealed: *They had all been employed from six to eight months and had received their training from the provider. *They had each received a work email regarding that there was to have been no rearranging of residents rooms or moving resident's furniture without prior approval from the nurse. *CNA S stated she would not have rearranged a resident's room or moved their furniture without talking to and getting permission from the nurse first. *CNA R stated she would have talked to the resident or a nurse and gotten permission before making any change to a resident's room. *CNA J stated she would visit with the nurse before moving a resident's furniture and also voiced she had not received any other education or shared in discussion residents' rooms and moving furniture.	F 684		

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

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F 684	Continued From page 12 Interview on 3/23/23 at 10:50 a.m. with resident care coordinator (RCC) E revealed: *She had been employed for two months. *She was aware and had been educated on the newly developed protocol for staff to get permission from the resident care coordinators before re-arranging resident rooms or moving their furniture. *Staff were educated on the newly developed protocol and had received an email with continued follow up occurring at the staff's daily line up meetings. *She was not aware of staff rearranging residents' furniture prior to or since the incident occurred with resident 37. Interview on 3/23/23 at 11:41 a.m. with director of nursing (DON) B revealed: *Resident rooms were arranged for resident's choice, convenience and safety. *There had been no set policy for resident's room arrangements as residents were different and it was to have been individualized. *Conversations needed to happen before room adjustments were made to ensure resident safety. *Since the incident involving resident 37 had happened they had developed a new protocol where the standard of practice was staff must visit with the resident care coordinators first and leaders were to have discussed as a team prior to the staff rearranging resident's rooms or moving resident's furniture. *During the survey the newly developed protocol was requested. *DON B stated they had not developed a written policy or protocol, she only had the emails that had been sent to the staff and meeting notes	F 684		

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F 684	Continued From page 13 from when meetings had taken place. *DON B stated they had completed many interviews with staff during their investigation and no one came forward during the investigation. *They had reported the incident to the South Dakota Department of Health, educated staff regarding the new protocol that had been developed, sent staff emails, followed up during staff's daily line ups and completed a sweep of the building to ensure resident's room arrangements were safe. *Since COVID nursing staff were completing on-line training's. *She was not aware if there was an on-line skin/wound training program. *Nurses communicated the resident's wound status and received physician orders for wound care by faxing a communication form to the resident's physician. *If a resident's wound was not healing or worsening a nurse would fax the physician and get an order for a wound care consult. 2. Observation and interview on 3/21/23 at 8:45 a.m. with resident 128 in her room revealed she: *Was lying in bed on her side and looked thin in appearance. *Was receiving hospice services and wanted "nature to take its course." *Stated her main concern was the inability "to get a laxative" like Milk of Magnesia which she had used at home. -Had only one bowel movement in the eleven days since her admission on 3/10/23. Review of resident 128's medical record revealed: *Her admission date was 3/10/23 and she began receiving hospice services on that same date.	F 684		

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F 684	Continued From page 14 *Hospice registered nurse (RN) T's 3/12/23 progress note: "Will plan to request prn [as needed] stool softener as patient verbalizes she has always had one in the past. She would like to try prune juice today to assist with bowels. I did update ECF [extended care facility] nurse on this request." *Medication orders signed on 3/13/23 by the resident's medical provider included the following orders: -Daily scheduled and as needed oral oxycodone-acetaminophen related to the resident's history of chronic back, neck, and coccyx pain. --That medication was an opioid with known side effects that included constipation. -Daily as needed oral senna (laxative) and daily as needed bisacodyl (laxative) suppository. *Hospice RN T's progress notes: -3/14/23: "She [resident 128] shares the prune juice did help her bowels and she was able to have a bowel movement yesterday." Information was reviewed with the facility nurse. -3/17/23: "Patient [resident] shares need for prn stool softener today. ECF nurse updated. Last bowel movement was 3/13/23. She continues to drink prune juice to help with bowels." *RN U's 3/19/23 faxed communication to the resident's medical provider included the following: -"Resident is requesting PRN MOM [Milk of Magnesia]. States this has worked the best for her in the past for occasional constipation. She currently only has PRN bisacodyl suppositories and PRN Senna 8.6 mg BID. She has been receiving PRN Senna (once on 3/18/23 and twice on 3/19/23) with no results and she is day six of no bowel movement. She refuses the suppository when offered." *Hospice RN T progress notes:	F 684		

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F 684	Continued From page 15 -3/21/23: Conferred with medication aide V ECF. "He also updates she [resident 128] has been requesting prn stool softener for constipation." "She is also requesting to have a scheduled stool softener to assist with bowels. I will plan to request this from the provider." *RN U progress notes: -3/22/23 at 9:58 a.m.: New orders were received for scheduled Senna 8.6 mg PO BID and PRN MOM. "PRN milk of magnesia given this morning...in addition to her scheduled Senna to help promote bowel movement." Resident declined a PRN suppository in lieu of trying the MOM first. 12:49 p.m.: Resident was reapproached about the use of a PRN suppository which she agreed to. "Hard stool present at rectum when inserted suppository. Small amount of hard stool removed with digital disimpaction." 1:31 p.m. "Extra large results from suppository that was given." Interview on 3/22/23 at 3:45 p.m. with resident 128 in her room revealed: *Her bowel movement earlier that afternoon "was the most painful thing" and "no one should have to go through that." *"I just couldn't get them [staff] to understand" her need to have regular bowel movements. Interview on 3/22/23 at 4:15 p.m. with resident care supervisor (RCS) D regarding resident 128 revealed: *She knew as a former hospice nurse that residents who were prescribed scheduled opioids were at increased risk for constipation without scheduled bowel management interventions. -Resident 128 should have had scheduled pharmacological and non-pharmacological bowel	F 684		

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F 684	Continued From page 16 interventions that were initiated at the time of her admission. *She was the provider's designee and was responsible for working with hospice staff to coordinate care for residents receiving hospice care services. -She had not reviewed resident 128's hospice orders. *Nursing staff had not followed the provider's Bowel Protocol policy that included consistent administration of ordered PRN laxatives and contacting the resident's medical provider on day four if the resident had no bowel movement. *"I can't even defend it" referring to the reason why the resident had gone nine days without having had a bowel movement. Interview on 3/22/23 at 4:50 p.m. with RN U regarding resident 128 revealed she was aware of the provider's bowel protocol and had followed it on the days she worked by administering ordered PRN laxatives and notifying the medical provider about the resident not having had a bowel movement. Interview on 3/23/23 at 10:15 a.m. with director of nursing B revealed: *Resident 128 should have had a scheduled laxative ordered at the time of her admission. *Nursing staff had not followed the Bowel Protocol policy. *Nursing staff, RCS D, and hospice RN T were expected to collaborate on RN T's visit days to assess symptom management and address in a timely manner any barriers to symptom management to ensure the comfort and quality of life of the hospice resident. Review of the June 2022 revised Bowel Protocol	F 684		

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F 684	Continued From page 17 revealed: *Residents at risk for constipation included those who routinely used narcotics. *For resident complaints of constipation and/or no bowel movements for two days: -"5.a. Day 2=offer Prune juice. -5.b. Day 3=give ordered PRN Milk of Magnesia or Miralax. -5.c. Day 4=Listen for bowel sounds. Give ordered PRN Dulcolax Suppository. -5.d. If still no results, consider contacting the Physician."	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure ongoing and timely skin assessments were conducted and documented by a licensed nurse prior to the development of pressure ulcers for two of two sampled residents (20, and 58). Findings include:	F 686	Skin Assessment Policy will be reviewed and/or revised by DON or designee to include ongoing and timely skin assessments to be conducted and documented by Licensed Nurse by 4/21/23. Nursing staff will be educated / re-educated on the skin assessment Policy by DON or designee by 4/21/23. A head-to-toe skin assessment will be done within 24 hours of admission and then weekly on all Residents and documented on skin inspect measure intervention. The weekly head to toe skin assessments will be completed on Residents first bath day of the week and/or weekly by Licensed Nurse by 4/21/23. Addendum: Charge Nurses will complete the head-to-toe skin assessments. Education/re-education will be provided to the Charge Nurses by the Staff Development Coordinator or designee on the steps to complete skin head to toe assessments by 4/28/23 4/20/23	4/21/2023

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F 686	Continued From page 18 1. Observation and interview on 3/21/23 at 10:38 a.m. with resident 20 in his room revealed he: *Was sitting in a wheelchair on a pressure relieving cushion. There was a pressure relieving cushion in his recliner and a pressure reduction mattress on his bed. *Had a colostomy, was able to empty the colostomy bag independently and the nurse changed the appliance every five days. *Received a shower with staff assistance once a week. *Had a prosthetic for his right lower leg, was able to put it on independently but was not wearing it because he had swelling in his leg and it would not fit at that time. *Had a CROW [Charcot Restraint Orthotic Walker]boot that was used to accommodate and support and keep his left foot from rolling to the outside and reduce pressure, but he was not wearing it because it caused a pressure ulcer to his left lower inner leg, that had healed. *Reported the nurses used a Betadine swab and painted a sore on his backside [buttocks], was going to wound care at the hospital for it, and the nurses had taken a picture of it weekly. *Reported the bath aide drying him off after his shower had seen the sore on his backside and reported it to the nurse. *Had no feeling or pain on his backside. *Had a sore on his backside several times before, they healed up and would come back in a different spot. *Was on a carbohydrate-controlled diet but had not always chosen to follow the diet. *Reported he exercised five days a week in the physical therapy department, but was unable to walk in the parallel bars without his prosthetic and the CROW boot.	F 686	Braden scale/skin risk assessment will be completed by Resident Care Coordinator (RCC) upon admission and then weekly x3 weeks, quarterly, annually and with change in Resident condition. Addendum: Resident Care Coordinators (RCC) have been provided education /re-education on Braden/Skin Assessment by the Staff Development Coordinator or designee on 4/19/23. TS 4/20/23 DON or designee will complete weekly head to toe skin assessment compliance audits x4 weeks. This will begin on 4/21/23. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may be reduced to twice monthly for one month. Monthly monitoring will continue for a minimum of 2 months. Results from audit will be reported by DON or designee to QAPI Committee and continue until the facility demonstrates sustained compliance.	

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F 686	Continued From page 19 *Reported his blood sugars ran high, it was 372 when checked by nursing during the interview, his physician was aware and had given the nurses orders for how to deal with his high blood sugars. Review of resident 20's medical record revealed: *He was admitted on 11/22/21. *The provider's Roster Matrix [a resident listing of pertinent care categories] indicated he had a facility acquired stage 3 pressure ulcer. *His diagnoses included insulin dependent type 2 diabetes with neuropathy, right below knee amputation, colostomy, pressure ulcer of the sacral region stage 3, limitation of activities due to disability, abnormality of gait and mobility, morbid obesity, muscle weakness, chronic kidney disease, and atherosclerotic heart disease. *The Minimum Data Set (MDS) assessments dated 11/8/23 and 2/7/23 coded him at risk for developing a pressure ulcer and he had a pressure reducing device for his bed and his chair. *His Brief Interview for Mental Status (BIMS) score was 14 on all the above MDS assessments, and indicated he was cognitively intact. *Blood sugars listed four times daily from 3/1/23 to 3/22/23 totaled 88 blood sugars ranging from 143 to 483. -19 blood sugars documented were greater than 400. -38 blood sugars documented were greater than 300. -23 blood sugars documented were greater than 200. -8 morning blood sugars documented ranged from 143 to 197. *All six Braden Scale scores (used to determine the risk of developing a pressure ulcer)	F 686		

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F 686	Continued From page 20 completed between 2/15/22 to 2/6/23 indicated he was at mild risk for developing a pressure ulcer. *Wound/Incision - Complex assessments completed by nursing dated 12/24/22 through 3/18/23 revealed resident 20 had a stage 3 pressure ulcer and was seen at the wound clinic weekly. *The wound clinic weekly visit documentation from 9/27/23 to 3/14/23 revealed: -Resident 20's chief complaint was "I have a sore on my backside" -Surgical History included: "coronary stents, mid foot amputation on the right - 11/2/20, right foot surgery - 9/3/2020 (9 times), decubitus surgery buttocks - 9/30/2020 (multiple), Colostomy, BKA [below knee amputation] (right)." -9/27/23 "Wound Assessment Wound #7 Sacral is an acute Stage 3 pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 0.5 cm length x 0.3 cm width x 0.2 cm depth, with an area of 0.15 sq [square] cm and a volume of 0.03 cubic cm. Necrotic adipose is exposed. No tunneling has been noted. No sinus tract has been noted. No undermining has been noted. There is a moderate amount of serosanguineous [thin watery fluid that is pink in color]drainage noted which has no odor. The patient reports a wound pain level of 0/10. The wound margin is thickened. Wound bed has No epithelial, No eschar, Yes slough, Yes bright red, pink, firm granulation." -2/7/23 "Wound Assessment Wound #8 Coccyx is an acute Stage 3 Pressure Injury Pressure Ulcer and has received a status of not healed. Initial wound encounter measurements are 2.5 cm length x 0.3 cm width, x 0.2 cm depth, with an area of 0.75 sq [square] cm and a volume of 0.15	F 686		

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F 686	Continued From page 21 cubic cm. Necrotic adipose [fat tissue] is exposed. No tunneling has been noted. No sinus tract has been noted, No undermining has been noted. There is an moderate amount of serosanguinous drainage noted which has no odor. The patient reports a pain level of 0/10 [a score of 0 meant no pain on a scale of 0 to 10, 10 indicating the worst pain ever felt]. The wound margin is unattached. Wound bed has no epithelialization, No eschar, Yes slough, Yes pink, firm granulation. *The wound care orders dated 3/14/23 read "Sacrum essentially resolved, DC [discontinue] dressing. BID [twice daily] Betadine paint for 10 days then DC. DC from routine FUP [follow up] unless new wounds develop or wound persists." Review of residents 20's comprehensive care plan regarding skin integrity was initiated on 10/3/22 and revised through 2/21/23 revealed: *"As evidenced by current impaired skin integrity and hx [history] of previous open area to coccyx/buttocks -2/21/23 new area - left inner calf. Resident wears CROW Boot, only wear 1-2 hours first day and slowly increase wear time monitoring skin-should not wear gripper socks-needs long sock over top of brace." -"2-21-23 collagen to right coccyx wound bed. cover with Optifoam Gentle. change every 4 days. -2-21-23 to left inner calf, apply Optifoam gentle to open area on inner left calf. change every 5 days and PRN until healed. Keep long socks on when wearing boot." Review of residents 20's comprehensive care plan regarding nutritional status initiated on 10/20/22 revealed: *"Moderately compromised status D/T [due to]	F 686		

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F 686	Continued From page 22 skin concern, abnormal labs, health risks from obesity, and needs therapeutic diet." -"Skin integrity - heal skin concern. Improve hgb/hct [hemoglobin and hematocrit] and A1C [a blood test that measured an average blood sugar level over the past three months] levels." -"Arginaid nutritional supplement with breakfast." -'Low Concentrated Carb[carbohydrate], No Added Salt diet." Observation and interview on 3/23/23 at 10: 11 a.m. with registered nurse (RN) P while performing wound care for resident 20 revealed: *Resident 20's ulcer to his coccyx was dry and scabbed over. *Orders from wound care were to paint the ulcer with Betadine through 3/24/23 and then stop the wound care. *The pressure reduction measures in place for resident 20 were a pressure reduction cushion in his wheelchair and recliner and a pressure reduction mattress on his bed. *He had an alternating air pressure reduction mattress when he had his last pressure ulcer but he had not had it since the previous pressure ulcer had healed. *Nurses completed a thorough skin assessment when a resident was admitted and then weekly for three additional weeks. *Braden scales for the identification of pressure ulcer risks were completed at admission and quarterly with the MDS. *Nurses had not completed routine skin assessments for residents other than for new admissions prior to the identification of a resident's skin concern. *Certified nursing assistants (CNA's) observed resident's skin during bathing and personal care and reported any concerns of redness, skin tears	F 686		

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F 686	Continued From page 23 or open areas to the nurse. *She was not sure if the CNA's had received specialized training for observing resident's skin and identifying skin concerns. *There was no designated wound care nurse. *The charge nurse was responsible for the resident's wound care on their scheduled shift. *Nurses and CNAs completed on-line training's and she had not received any specialized wound care training. *If a resident's wound was not improving or was worsening the charge nurse would fax the physician and get an order to send the resident to the wound care clinic. 2. Observation and interview on 3/21/23 at 10:30 a.m. with resident 58 revealed she: *Was sitting in her wheelchair watching television and her call light was clipped to her shirt. *Had a pressure reduction cushion in her wheelchair. *Had socks and tennis shoes on her feet. *Had her bed in the lowest position. *Had heel protector boots setting on the floor next to her recliner. *Was not responding verbally when spoken to and was determined to be non-interviewable. Review of resident 58's medical record revealed: *She was admitted on 6/9/21. *Her diagnoses included Alzheimer's disease, dementia, diarrhea, urinary incontinence, and pressure ulcer of the left heel. *The MDS assessments dated on 11/29/22 and 2/27/23 coded her at risk for developing a pressure ulcer and she had a pressure reducing device for her bed and chair. *Her BIMS score was 1 on all the above MDS assessments, and indicated she had severe	F 686		

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F 686	Continued From page 24 cognitive impairment. *The provider's Roster Matrix indicated she had a facility acquired stage 3 pressure ulcer. *All Braden Scale scores completed between 11/30/22 to 1/3/23 indicated she was at mild risk for developing a pressure ulcer. *The 11/30/22 Braden Scale assessment documentation listed activity as ordered, skin care products, hygiene, specialty bed mattress and specialty cushions interventions that were in place. *The 12/20/23 Braden Scale assessment documentation listed activity as ordered, offload bony areas, elbow/heel protectors, skin care products, hygiene interventions that were in place. *Wound/Incision - Complex assessments completed by nursing started on 12/9/22 through 1/6/23 documented the left heel with a deep tissue injury [purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear], described as purple, black, dark red, and boggy. *The initial Wound/Incision - Complex assessment completed by nursing dated 12/9/22 had the wound measurements as 2.5 cm length x 4.0 cm wide and the wound area as 10 cm. *Physician communication fax dated 1/30/23 were orders for resident 58 to have been seen "by podiatry at wound care at hospital". *Progress notes from the wound clinic dated 2/3/23 documented "Wound Assessment - Wound #1 Left heel is chronic Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2 cm length x 4 cm width x 0.1 cm depth, with an area of 8 sq cm and a	F 686		

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F 686	Continued From page 25 volume of 0.8 cubic cm. No tunneling has been noted. No sinus tract has been noted. No undermining had been noted. *There was no drainage noted. The patient reports a wound pain level of 0/10. Wound bed has not epithelialization, Yes eschar, No slough, No granulation". *Progress notes from the wound care clinic dated 2/3/23 documented orders for dressing as "apply primary dressing - betadine gauze, dry gauze and cloth tape. Change daily". Review of residents 58's comprehensive care plan regarding skin integrity and nutrition dated 11/28/22 with a revision date of 2/20/23 revealed: *She had a pressure ulcer to her left heel. *She received Boost Breeze at breakfast and chocolate Boost Plus a supplement at the noon meal. *Nursing staff were applying topical iodine, gauze and tape daily. *No other interventions were listed on the skin integrity care plan. Observation and interview on 3/23/23 at 9:49 a.m. with registered nurse (RN) P while completing wound care for resident 58 revealed: *Resident 58 was sitting in her recliner with no pressure reduction cushion and she had heel protector boots on both feet. *Her wheelchair was next to her bed and it had a pressure reduction cushion on it. *There was a pressure reduction mattress on her bed. *Resident 58's pressure ulcer to her left heel was intact, black/brown, firm dry area, dry and scabbed over. *Orders from wound care were to apply topical Betadine, cover with gauze and tape in place daily.	F 686		

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F 686	Continued From page 26 *The pressure reduction measures in place for resident 58 were a pressure reduction cushion to have been used in her wheelchair and her recliner, a pressure reduction mattress on her bed, and heel protector boots, *Nurses completed a thorough skin assessment when the resident was admitted and then weekly for three additional weeks. *Braden scales for the identification of pressure ulcer risks were completed at admission and quarterly with the MDS. *Nurses did not complete routine skin assessments other than for new admissions, prior to the identification of a resident's skin concern. *CNAs observed resident's skin during bathing and personal care and reported any concerns of redness or open areas to the nurse. *She was not sure if CNAs had received specialized training for observing skin and identifying skin concerns. *There was no designated wound care nurse. *The charge nurse was responsible for the resident's wound care on their scheduled shift. *Nurses and CNAs completed on-line training and she had not received any specialized wound care training. *If a resident's wound was not improving or was worsening the charge nurse would fax the physician and get an order to send the resident to the wound care clinic. Interview on 3/22/23 at 9:22 a.m. of licensed practical nurse (LPN) Q while performing another task revealed: *Braden scales were completed for residents at the time of admission and then quarterly with the MDS. *Skin assessments were completed by nursing for residents at the time of admission and then	F 686		

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F 686	Continued From page 27 weekly for an additional three weeks. *Skin/wound assessments for the residents with identified skin wounds were completed on Saturdays and Sundays by the charge nurse working that shift and wound measurements were completed at that time. *If residents wounds were not improving or worsening they were referred to the wound care clinic. *Skin observations were done by CNAs during resident personal care and bathing and they notified the nurse if they saw any skin concerns such as redness, bruises, skin tears etc... *She denied being aware of CNAs receiving any additional skin/wound training other than what they received during their CNA course. *She denied that nursing completed routine skin assessments for residents at risk for pressure ulcers prior to the identification of a pressure ulcer. *She completed on-line training's and had not received any specialized wound care training. Interview on 3/23/23 at 8:59 a.m. with assistant director of nursing (ADON) C revealed: *Head to toe skin assessments were completed in the evening by the night shift charge nurse when a resident was admitted. *The charge nurse worked a twelve hour shift. *Braden scales were completed for residents at the time of admission and then quarterly with the MDS by the resident care coordinators. *Pressure ulcer prevention measures put into place for residents at risk for developing a pressure ulcer were repositioning schedules, specialty mattresses for pressure reduction, wheelchair/recliner cushions and some of the residents had pressure reducing boots. *CNAs completed skin observations during	F 686		

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F 686	Continued From page 28 resident's personal care and bathing and reported any skin concerns of redness or open areas to the nurse. *She was not aware if there had been a procedure or protocol set up and in place for nurses to complete routine skin assessments for residents at risk for developing a pressure ulcer. *The charge nurse completed residents wound care and sent a fax to the resident's physician with communication of the wound status and for new orders. *The resident care coordinators were consulted if a resident's wound was not improving or was worsening. *The resident care coordinators were assigned and completed the same on-line training's as the other nurses. *The would have utilized outside referrals to consult with the wound care clinic. *She felt the nursing staff had the education and knowledge to obtain a physician order for a wound care consult for residents with wound changes, non-healing wounds or a decline in the wound status. Interviews on 3/23/23 between 10:35 a.m. and 11:20 a.m. with CNAs S, R, and J revealed: *They had all been employed from six to eight months and had received their on-line training and training from the provider. *In their roles, they were to observe residents skin during bathing and personal cares and report any skin concerns such as redness, skin tears, or open areas to the nurse. *They had not received any additional training for observing skin concerns other than what was included during their training. *They were aware pressure ulcer prevention interventions utilized for residents identified as at	F 686		

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F 686	Continued From page 29 risk for skin breakdown were: repositioning, toileting schedules, applying barrier cream, cushions, heel boots, and pressure reducing mattresses. Interview on 3/23/23 at 10:50 a.m. with resident care coordinator (RCC) E revealed: *She had been employed for two months. *She had received training for completing admission, discharges, care conferences, the MDS assessments, and helping staff that worked with residents. *Braden Scale assessments were completed with residents at the time of admissions, and then quarterly with the MDS assessments. *Resident skin assessments were completed at the time of admission, then weekly for an additional three weeks, quarterly, and annually with the MDS assessments. *She had not received any specialized wound care training. *CNAs completed skin observations while providing residents personal cares and bathing and reported any skin concerns such as redness or open areas to the charge nurse. *She was not aware if the CNAs received any skin care education beyond the CNA certification program. Interview on 3/23/23 at 11:41 a.m. with director of nursing (DON) B revealed: *Nurses completed head to toe skin assessments for residents at the time of admission, then one time weekly for 3 additional weeks, and then quarterly and annually with the completion of MDS assessments. *Braden Scale assessments were completed at the time of admission, quarterly and annually with the MDS assessments.	F 686		

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F 686	Continued From page 30 *Residents found to have been at risk for pressure ulcers were discussed at interdisciplinary (IDT) team meetings, therapy would have been involved and interventions were put in place such as a restorative program, repositioning, good nutrition, pressure reduction mattresses, cushions, and the family and physician were updated. *CNAs were observing resident's skin during bathing, personal care, repositioning and reporting skin concerns to the nursing staff and that was how resident skin concerns or issues were identified. *There was no process in place for nurse skin assessments to have been completed, for residents identified at risk for pressure ulcer development. *Prior to COVID they had nursing staff attend wound workshops and had wound care training events with wound care. *She was not aware if there was an on-line skin/wound training program or if CNAs had received additional training for completing skin observations outside of what they had received in their CNA certification course. Review of the provider's 6/2021 Skin Assessment policy revealed: *"It is the policy of this facility that all residents will be routinely monitored for impaired skin integrity. Measures will be taken to predict residents at risk and implement individualized preventive interventions as needed. In the event impaired skin integrity unavoidably develops, individualized interventions will be implemented to promote rapid healing." -"5. Weekly assessments will be completed by a licensed professional and updated on the weekly skin assessment sheet."	F 686		

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F 686	Continued From page 31 Review of the provider's 10/2021 Pressure Ulcer Prevention Policy and Procedure revealed: *"A pressure ulcer risk assessment (Braden scale) will be done on admission and repeated at defined intervals. Skin assessments will be done on admission and repeated at defined intervals. Interventions will be implemented to reduce the risk of developing pressure ulcers by managing moisture, optimizing nutrition and hydration, and minimizing pressure. all related assessments and interventions will be documented. -A. Assessment --1. Perform Braden Scale risk assessment to identify pressure ulcer risk --2. Perform skin assessment" --"5. Identify all individual risk factors" -"B. Interventions --1. Implement interventions based on Braden Scale score ---At Risk: Braden score 15 to 18 ---Moderate Risk: Braden Scale score 13 to 14 ---High Risk: Braden Scale score 10 to 12 ---Very High Risk: Braden Scale score 9 or below" *"This policy applies to personnel responsible for skin assessments, risk assessments and interventions to reduce the risk of developing pressure ulcers by managing moisture, optimizing nutrition and hydration, and minimizing pressure. All nursing personnel are expected to inspect and protect their patient's skin. Nursing is responsible for assessment and plan of care; the LPN and non-licensed personnel are responsible for skin inspection, implementation of plan of care and reporting any changes in skin condition to the RN. *"Leadership is responsible for ensuring there is a system-wide awareness of the patient safety performance goal of providing pressure ulcer prevention measures. Leadership is responsible	F 686		

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F 686	Continued From page 32 for making the investment in resources required to meet the goal, analyzing performance gaps, and reporting the performance gaps as indicated by metrics to corporate level." *"Appropriate staff must be competent in use of the Braden Scale, skin assessment, proper repositioning techniques and proper use of related equipment."	F 686		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, cleaning checklist review, and policy review, the provider failed to: *Clean six of six hood vent covers on a regular schedule to prevent the buildup of dust. *Properly clean and delime one of one	F 812	The 6 hood vents were cleaned on 4/13/23. Professional cleaners will clean venting twice annually and hood filters monthly. Cleaning will be done more often as needed. Dishwasher will be de-limed weekly and as needed the outside of the dishwasher, including seals and seams will be de-limed daily, and as needed. Staff education completed by Hospitality Services Manager by 4/21/2023. Vent above dishwasher has been cleaned and will be cleaned professionally twice annually and as needed. Cleaning checklist revised to include monthly oven cleaning as needed. Grease trap door emptied and cleaned twice daily and as needed. Equipment to be moved twice annually and cleaned. Revised Policy FN216 – Facility Resident Refrigerators Policy. Food service staff will be responsible for cleaning and disposal of outdated foods after 3 days. Dietary staff removed outdated foods items including the noted items; yogurt, soup, cottage cheese, peached, blueberries and salami. Addendums:1) diswasher will be added to checklist. 2) Staff will be educated/ reeducated on policy revisions by Dietery Manager. 4/21/23	4/21/2023

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F 812	Continued From page 33 dishwasher to prevent limescale buildup. *Ensure one of one vent duct above the dishwasher remained free from dust buildup. *Maintain the following food preparation equipment in a clean and sanitary manner that was free from burnt food particles and grease buildup: -One of one fryer. -One of one flattop grill grease trap drawer. -Three of three conventional ovens. -Two of two convection ovens. *Properly label food items and discard expired foods in two of two foodservice kitchenette freezer/refrigerator units and two of two resident's communal freezer/refrigerator units. 1. Observation on 3/21/23 from 8:22 a.m. to 8:50 a.m. in the kitchen revealed: *The hood vent covers above the main cooking equipment were clamped into place. -The clamps and hood vent covers were coated with a layer of dust. -There was a sticker which indicated the vent ducts were last professionally cleaned on 9/22/22. *The inside surfaces of the convection and conventional ovens had numerous burnt-on food particles and grease spots. *The grease trap drawer that was attached to the flattop grill was filled with grease, fat, and food particles. -The drawer was difficult to open due to the amount of debris. *The fryer was to the right of the flattop grill. -There were multiple specks of food particles and fryer oil splattered in between the gap of the fryer and the flattop grill. *The vent duct above the dishwasher was caked with clumps of dust. *The dishwasher had a crusty layer of limescale	F 812	New clamps were installed on the hood vents on 4/12/23. Monthly audit of Dietary Facilities and equipment including cleaning of dishwasher, convection ovens and grease trap drawer will be completed by the Dietary Manager or designee. Audits will be reported by the Dietary Manager to the QAPI Committee until the facility demonstrates sustained compliance as determined by the QAPI Committee until advised to discontinue.	

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F 812	Continued From page 34 buildup on the outside seams of the dishwasher doors. 2. Interview on 3/22/23 at 11:01 a.m. with cook M about how often the ovens were cleaned revealed: *They tried to deep clean the ovens once a month. *If there was a major food spill, then it was cleaned right away. Interview on 3/22/23 at 11:18 a.m. with lead nutrition and food service worker (LNFS) I about kitchen cleaning practices revealed: *They deep cleaned the ovens once a month with an oven cleaner. *They cleaned the fridges once a week. *The dishwasher was wiped down and cleaned once a day, and delimed once a week. *The maintenance department was responsible for cleaning the vent ducts. Interview on 3/23/23 at 11:26 a.m. with nutrition and food service (NFS) staff N and LNFS I about cleaning the dishwasher revealed: *At the end of each day, NFS staff N would drain the dishwasher, clean out the strainer bucket, and refill the dishwasher. *They would delime the inside of the dishwasher once a week. *They both stated they had not cleaned the outside of the dishwasher very often. *They indicated that maintenance would know more information about how often the vent duct above the dishwasher was cleaned. 3. Observation on 3/22/23 at 2:07 p.m. of the Abby and Dakota freezer/refrigerator units revealed:	F 812		

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F 812	Continued From page 35 *The resident communal freezer/refrigerator unit was black in color and was padlocked shut. *Inside the refrigerator compartment, there were: -Several containers of food that were expired: --One Mason jar labeled "Peach" with a date of "3/22/22." --One container of Chobani brand yogurt with a date of "Sept. 08 2022." --One container of foul-smelling cottage cheese that had turned brown in color with a "Best if used by" date of 7/17/22. -Multiple food items that were not labeled or dated: --Two bags of sliced salami meat. --One container of an orangish-brown thick substance. --One Mason jar filled with a red liquid. *Inside the freezer compartment, there was a container of an unidentified purple substance that was labeled "[resident's name] 2/6/22." *The foodservice freezer/refrigerator unit was white in color and was padlocked shut. *In the refrigerator compartment, there was a container of what looked like pickles or cucumbers that was not labeled or dated. *In the freezer compartment, there was a bag of what looked like hamburger patties that was not labeled or dated. Observation on 3/22/23 at 2:22 p.m. of the Boardwalk and Cedar freezer/refrigerator units revealed: *The resident communal freezer/refrigerator unit was black in color. *Inside the refrigerator compartment, there were several items that were not labeled or dated: -One glass bowl with a plastic lid of a foul-smelling food that appeared to have been soup.	F 812		

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	435042	A. BUILDING _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

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F 812	Continued From page 36 -One cup of an unknown brown liquid with a date of 3/8. -One bag of what appeared to be a pie. *The foodservice freezer/refrigerator unit was white in color and located in the Cedar dining room kitchenette. -In the refrigerator compartment, there was a bowl of blueberries with a white fuzzy growth that was dated 3/17. -In the freezer compartment, there was an uncovered bowl of ice cream that was not labeled or dated. 4. Interview on 3/22/23 at 2:38 p.m. with hospitality services manager (HSM) F about the observations in finding 3 revealed: *The foodservice staff were responsible for properly labelling foods with the food item and date in the foodservice refrigerators. *It was unclear who was responsible for labelling/dating foods in the resident communal refrigerators. *She said it should have been a collaborative effort between nursing and foodservice staff. *She was not aware of the unlabeled and expired food items in the resident communal refrigerators. Continued interview on 3/22/23 at 3:07 p.m. with HSM F about her role and expectations in the foodservice department revealed she: *Had been in her position since November 2021. *Was unsure when the hood vent covers were last cleaned. -She thought maintenance was in charge of cleaning the hood vent covers. -She agreed the hood vent covers and the vent duct above the dishwasher were dusty and should have been cleaned.	F 812		

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F 812	Continued From page 37 *Stated she was unsure when the last time the food preparation equipment (conventional ovens, fryer, convection ovens) was moved away from the walls to deep clean. *Expected her staff to wipe down the ovens weekly, and deep clean the ovens with an oven cleaner monthly. -She agreed it looked like the ovens had not been deep cleaned in a long time due to the amount of burnt food on the insides of the ovens. *Expected her staff to clean the dishwasher daily, and delime the dishwasher weekly. -She was not aware that staff were not cleaning the outside of the dishwasher. -They had a difficult time with keeping the dishwasher free from limescale buildup due to the water hardness. 5. Interview on 3/22/23 at 4:15 p.m. with maintenance director O and HSM F about the hood vent covers revealed: *A professional duct cleaning service came every six months to clean the facility's ventilation ducts. *Maintenance director O said the kitchen staff were responsible to clean the hood vent covers monthly. -They were supposed to unclamp the hood vent covers, slide them out, and put them through the dishwasher to clean them. *HSM F indicated that her staff had not cleaned the hood vent covers, and had not completed that task since she had started working at the facility. -She was not aware that she and her staff were supposed to have been cleaning the hood vent covers monthly. 6. Review of the provider's 04/2021 "Sanitary Conditions" policy revealed: *Policy statement: "The food service will be	F 812		

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F 812	Continued From page 38 maintained in a clean and sanitary manner in storing, preparing, distributing and serving food properly to prevent food borne illness." *Procedure section: -"3. All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects." -"4. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas." 7. Review of the provider's 12/2022 "Foods Brought in by Family & Visitors" policy revealed: *Policy statement: "It is the policy of this facility that foods brought in from family and visitors, for resident consumption, will be appropriately stored, handled and consumed." *Procedure section: -"D. Families will receive this safe food handling information as part of the welcome booklet received at the time [of] admission. Information on the following areas will be included ..." --"4. Proper labeling and dating of each item" --"5. Leftover foods will be used within 3 days or discarded" -"F. Refrigerated items shall be in tightly sealed containers and marked with the resident's name, food item, and current date. These items will be stored in a designated area in the facility's refrigerator until service time." -"G. Families will be encouraged to take left over food home. Uneaten portions of leftovers cannot be stored in resident's room. Leftovers cannot be returned to the facility's refrigerator." 8. Review of the provider's "Dakota Cleaning List"	F 812		

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F 812	Continued From page 39 and "Cedar Cleaning List" for 3/1/23 through 3/18/23 revealed: *Employee initials had been marked each day for the line item "Clean [Refrigerator] (check for outdates, and make sure food is all labeled)" 9. Review of the provider's "Cook Cleaning List" for 3/1/23 through 3/18/23 revealed: *Employee initials had been marked each day for the following line items: -"Clean ovens (Front or Back)" -"Clean fryer (as needed)" 10. Review of the provider's "Main Cleaning List" for 2/1/23 through 3/25/23 revealed: *Employee initials had already been marked for each line item for 3/24/23 and 3/25/23, even though the survey had ended on 3/23/23. *Employee initials had been marked for the line item of "Delime Dish Machine Fridays" for the following dates: -2/3/23, 2/10/23, 3/3/23, 3/17/23, 3/18/23, and 3/24/23. 11. Documentation indicating when the last time the professional duct cleaning service had last cleaned the ducts was requested from maintenance director O on 3/22/23 at 4:15 p.m. The requested documentation had not been provided by the end of the survey on 3/23/23 at 1:10 p.m.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services	F 849	Hospice Services and Bowel Protocol Policies will be reviewed and revised to include collaboration of Resident Cares between Hospice Services and the Avera Mother Joseph Manor Interdisciplinary team by 4/21/23.	4/21/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 849	Continued From page 40 through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical,	F 849	All Hospice and Avera Mother Joseph Manor staff involved in the care of Hospice residents will receive education / re-education on the Hospice Services and Bowel Protocol Policies by 4/21/23. The Care Plan for Resident 128 and all other Hospice Residents will be reviewed and revised by the Resident Care Coordinator (RCC) to ensure an integrated plan of care to maintain the Residents highest practical, mental, and psychosocial well-being by 4/21/23. All Hospice Residents medications will be reviewed by the LTC Consultant Pharmacist for scheduled narcotic use. Once determined, collaboration will occur between the Resident, Hospice Services, and Interdisciplinary Team to develop an individualized plan of care to meet the needs of the Residents and their bowel protocol regimen by 4/21/23. To collaborate with Avera Mother Joseph Manor, Hospice Services will place a green binder on each Nursing Neighborhood. Within the green binder will be a different tab for each hospice patient on that Neighborhood. It will also be divided out into the service line categories of Nurse, Aide, Social Work, Chaplain, and POC. At each Hospice visit, the Hospice staff will chart in the Meditech Homecare, print off their documentation, and place it in the appropriate slot in the green binder. This will be implemented by Hospice services or designee by 4/21/23.	

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F 849	Continued From page 41 mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must	F 849	The only exception to this will be the initial nurse admit documentation, which will be expected to be finished within 24 hours of admit and faxed to Avera Mother Joseph Manor with Attention to the Resident Care Coordinator and/or current Charge Nurse. Addendum: Staff will be educated/ re-educated by the Staff Development Coordinator or designee on Hospice Services Green Binders by 4/21/23. The education will include: To collaborate with Avera Mother Joseph Manor, Hospice Services will place a green binder on each Nursing Neighborhood. Within the green binder will be a different tab for each hospice patient on that Neighborhood. It will also be divided out into the service line categories of Nurse, Aide, Social Work, Chaplain, and POC. At each Hospice visit, the Hospice staff will chart in the Meditech Homecare, print off their documentation, and place it in the appropriate slot in the green binder. This will be implemented by Hospice services or designee by 4/21/23. The only exception to this will be the initial nurse admit documentation, which will be expected to be finished within 24 hours of admit and faxed to Avera Mother Joseph Manor with Attention to the Resident Care Coordinator and/or current Charge Nurse. 4/21/23	

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F 849	Continued From page 42 report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners	F 849	Hospice Services or designee will audit the above collaboration for compliance monthly, for a total of 6 months. RCC or designee will audit Residents care plan monthly for a total of 6 months to assure an integrated plan of care has been developed for Hospice Resident, effective pain management and compliance with bowel protocol. Audit results will be reported by Hospice Services, RCC or designee to the QAPI Committee Quarterly until the facility demonstrates sustained compliance as determined by QAPI Committee.	

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F 849	Continued From page 43 participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an integrated plan of care had been developed for one of one sampled resident (128) receiving	F 849		

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F 849	Continued From page 44 hospice services. Findings include: 1. Observation and interview on 3/21/23 at 8:45 a.m. with resident 128 in her room revealed she: *Was lying in bed on her side and looked thin in appearance. *Had fallen prior to her admission but had not had a fall since she het admission. *Was receiving hospice services and wanted "nature to take its course." *Stated her main concern was the inability "to get a laxative" like Milk of Magnesia which she used at home. -Had only one bowel movement since her admission on 3/10/23. *Attended Catholic mass and had a supportive family. *Ate her meals in the dining room. Review of resident 128's medical record revealed: *Her admission date was 3/10/23 and on that same date she was started on hospice services. *Hospice nurse T's 3/10/23 through 3/21/23 progress notes revealed the resident had: -A terminal diagnosis of severe anemia. -Accepted the following hospice services: nurse, nurse aide, social worker, and chaplain visits. -A history of chronic neck, back, and coccyx pain. -Expressed a fear of falling and not wanting to become addicted to the pain medication she was receiving. -Voiced the need for a stool softener like the one she was accustomed to using at home. Review of resident 128's comprehensive care plan last revised on 3/18/23 revealed: *A Hospice Care Problem included the following Interventions:	F 849		

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F 849	Continued From page 45 -The first name of hospice nurse T was identified as the "primary nurse" and there was a "hospice aide for bathing" -"See visit schedule [for hospice staff] in communication book" -"Contact hospice team with any physical/emotional changes" --There was no indication of how often these disciplines were to have been in the facility to assess the resident or what type of supportive care they were expected to provide during their visits. --There was no documentation regarding a social work or chaplain visits. --There was no mention of the resident's terminal diagnosis. --There was no mention of her choices such as rehospitalization, what care she wanted in the event of an acute illness or injury or any goals she had related to her terminal diagnosis. -"Do not push food/fluids as it may cause adverse effects" --That intervention had not been re-evaluated for appropriateness based on the resident's history of and current issues with constipation. *Bowel and Bladder Problem Interventions: -Failed to identify the resident's history of constipation, her increased risk for constipation based on her narcotic use, pharmacological or non-pharmacological constipation management interventions. *Pain Problem Interventions: -Included the use of a daily pain assessment but had not identified pharmacological or non-pharmacological pain management interventions, or what the resident had identified as an acceptable level of pain for her. Interview and review of resident 128's	F 849		

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F 849	Continued From page 46 comprehensive care plan with resident care supervisor D on 3/22/23 at 3:45 p.m. revealed: *She was the designee responsible for working with hospice to coordinate care for residents receiving hospice care services. *All interdisciplinary team members were responsible for care plan development, review, and revision but she was responsible for accountability of the overall care plan process *Staff used information contained in the resident's care plan for guidance on how to direct a resident's care. *Resident 128's hospice care plan had not reflected coordinated care and services between the provider and the hospice provider or the resident's individualized hospice care needs and choices. Interview on 3/23/23 at 10:15 a.m. with director of nursing B regarding resident 128's hospice care plan revealed it had not reflected a collaborative effort between the provider and the hospice provider regarding the hospice services and interventions expected to have been provided to that resident. Review of the last revised July 2013 Hospice Services policy revealed: *"4. Hospice and facility will at this first meeting review and integrate the current plan of care with Hospice." *"5. The integrated plan of care will be updated and revised as necessary to reflect the resident's current status." *"7. The plan of care will include directives for managing pain and other uncomfortable symptoms."	F 849		
F 880	Infection Prevention & Control	F 880	The Hand Hygiene, E-Z lifts and Slings,	4/21/2023

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F 880 SS=E	Continued From page 47 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	F 880	COVID-19 Room Trays and COVID-19 Room Cleaning Policies will be reviewed and revised by Department Manager, DON or designee by 4/21/2023. All facility staff who provide or are responsible for the above cares and services will be educated / re-educated by the Department Manager, DON or designee by 4/21/2023 DON, ADON or designee will complete a Root Cause Analysis answering the 5 whys for the identified cares of a Hand Hygiene, E-Z Stand lifts and slings, COVID-19 Room Trays and COVID-19 Room Cleaning and provide all facility staff education / re-education by the Department Manager, DON or designee by 4/21/2023. Avera Mother Joseph Manor is currently purchasing additional E-Z stand slings, with the goal of supplying each resident requiring a sling, to have their own. This will be completed by 4/28/2023 pending no issue with supply and demand. ADON or designee will meet with the South Dakota Quality Improvement Organization (QIN) on 4/17/2023 to identify the root cause analysis for future infection prevention strategies. A brief detail of the discussion will be completed by 4/21/2023.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

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F 880	Continued From page 48 resident; including but not limited to: (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: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following: *Routine cleaning and disinfection of high touch surfaces in the semi-private room shared by one of one COVID-19 positive resident (48) and her roommate (71). *Proper handling and disposal of mealtime utensils used by one of one COVID-19 positive	F 880	Addendum: DON and ADON held a conference call with Susan Wilcox, Quality Improvement Advisor for QIN on 4/17/23 regarding the directed plan of correction following a recent SDDOH Survey conducted at Avera Mother Joseph Manor. We developed a POC utilizing the root cause analysis and included measurable goals with audits/ monitoring, identifying responsible staff designees, timelines, education, and documentation on Hand Hygiene, COVID 19 room trays, COVID 19 Room cleaning, and E-Z stand lifts and slings. Susan also provided us with some additional resources including, but not limited to education videos, power point slides and communication tools to be utilized when/if needed. Root Cause Analysis: 5 Whys 1. Inappropriate disposal of mealtime items and utensils 2. Tray left uncovered in hallway. 3. Unsure who left tray there. 4. Cart Labels/Directions not in place 5. Dietary assumed that Nursing would take care of it and Nursing assumed that Dietary would take care of it. Root Cause: A process was not properly put into place for tray placement and tray pick up for COVID 19.	

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F 880	Continued From page 49 resident (48). *Appropriate glove use and hand hygiene had been performed during morning personal care for one of one sampled resident (31). *Appropriate cleaning and sanitizing of the E-Z stand mechanical lift and the body sling between two of two residents (12 and 31). Findings include: 1. Observation on 3/21/23 at 8:55 a.m. outside of resident 48 and 71's semi-private room revealed: *Airborne precaution signage for COVID-19. -Personal protective equipment use: gown, gloves, eye protection, and N-95 mask inside of that room. *The start date of those precautions had begun on 3/13/23 and the end date was 3/23/23. Observation and interview on 3/21/23 at 12:30 p.m. with lead nutrition and food service worker I revealed: *A serving tray with Styrofoam plates, cups, and utensils laid uncovered on a wheeled cart outside of residents 48 and 71's room. -Scrambled egg remnants were visible on the Styrofoam plate. *With ungloved hands lead nutrition and food service worker I removed the tray, carried the tray towards the enclosed food cart down the hall, then turned back around and carried the tray back to the wheeled cart. -She pulled that wheeled cart behind her with one hand and pushed the enclosed food cart with her other hand down Abbey Hall, through another hallway, and into the kitchen. *Lead nutrition and food service worker I confirmed: -The serving tray referred to above was resident 48's breakfast tray.	F 880	Addendum cont. 5 Whys 1. Inappropriate hand hygiene and glove use during personal cares 2. Staff did not perform duties to meet policy compliance. 3. New CNA performing tasks in front of a surveyor, resulting in increased anxiety. 4. Annual Survey at Facility 5. Need to follow regulations and policies to ensure safe care to remain open as a facility. Root Cause: Guidelines for hand hygiene protocols need to be implemented and followed as a requirement at MJM for Resident Safety and Quality of Care. 5 Whys 1. Inappropriate maintenance that included cleaning and sanitation of E-Z stand mechanical lifts and slings between Residents. 2. Newer staff performing tasks in front of Surveyors resulting in increased anxiety and not thinking clearly. 3. Lack of Sling supply to provide each Resident their own. 4. Staff uncertainty causing incorrect cleaning and disinfecting procedure. 5. Staff unclear on protocol for sharing Residents slings if used over clothing.	

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F 880	Continued From page 50 -The resident had COVID-19. -The tray should not have been left uncovered and unattended outside of the resident's room. -She should not have handled the food tray without gloved hands. -The tray should have been covered prior to transporting it to the kitchen. 2. Interview on 3/21/23 at 11:40 a.m. with certified nurse assistant (CNA) G revealed: *Resident 48 was independent with her self-care and was able to use the shared sink outside of the bathroom and the toilet inside of the bathroom on her own. *Resident 48's roommate resident 71 was not positive for COVID-19. -She had a stroke history resulting in impaired use of her right side. -She required staff assistance to use the sink and the toilet she had shared with resident 48. Interview on 3/21/23 at 12:15 p.m. with resident 48 revealed she: *Was immunocompromised and that was the fifth time she had COVID-19. -Her current symptoms were sinus congestion, some coughing, "popping" ears, and she had been told today she had a "low grade temp [temperature]." *Kept the privacy curtain around her living space enclosed. *Was able to use the shared sink and toilet on her own. Interview on 3/21/23 at 11:51 a.m. with housekeeper H regarding cleaning and disinfection of resident 48's room revealed: *She had been employed by the facility for approximately 19 years.	F 880	Addendum cont. Root Cause: Facility increasing stock of lift slings to ensure all Residents have their own designated sling. If a sling becomes soiled, it will be laundered. Mechanical lift will be cleaned and disinfected between the Residents. 5 Whys 1. Inappropriate routine cleaning and disinfection of high touch surfaces in semi-private rooms occupied by COVID and Non-COVID Residents. 2. No cleaning supplies accessible in Resident rooms. 3. Did not want to leave cleaning supplies in way of Resident. 4. No appropriate/safe place to store them. 5. For safety of Resident, supplies kept outside of room. Root Cause: Ensure Resident safety of leaving cleaning products in Resident room in designated area. 4/20/23	

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F 880	Continued From page 51 *Caregivers were responsible for cleaning COVID-19 positive rooms. *Non COVID-19 resident rooms were cleaned daily using an Environmental Protection Agency (EPA) approved disinfectant. Observation on 3/21/23 at 1:00 p.m. of CNA G inside of residents 48 and 71's room revealed she: *Transported resident 71 in her wheelchair into the shared bathroom to use the toilet. -After assisting her to stand using a gaitbelt the resident was instructed to hold the wall-mounted grab bars to remain upright while CNA G lowered her undergarments. *Assisted the resident onto the toilet riser to use the toilet. *Had not used a bleach wipe or other EPA approved cleaning product to disinfect the grab bars, toilet or sink prior to or after assisting resident 71 with toileting. Interview on 3/22/23 at 9:55 a.m. with CNA G revealed: *Housekeeping staff were responsible for cleaning all resident rooms including those who had COVID-19. -That included disinfection of the bathroom and sink shared by residents 48 and 71 in their room. *She had not been given any specific instruction regarding the disinfection of the shared sink or bathroom in between use by residents 48 and 71. Interview on 3/22/23 at 5:20 p.m. assistant director of nursing/infection prevention nurse C regarding the observations referred to above revealed: *Bathroom and sink cleaning was expected to have been cleaned and disinfected with an	F 880	DON or designee will conduct auditing and monitoring on the identified items of Hand Hygiene, E-Z Stands lifts and slings, COVID-19 Room Trays and COVID-19 Room Cleaning 2-3 times weekly over all shifts to ensure effective implementation and ongoing sustainment, staff compliance and any other area identified through the root cause analysis. This will begin 4/17/2023. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may be reduced to twice monthly for one month. Monthly monitoring will continue for a minimum of 2 months. Results from audit will be reported by the DON, ADON or designee to QAPI Committee and continue until the facility demonstrates sustained compliance. ADON (Infection Control Nurse) currently participates in weekly infection Prevention touchpoint discussions with Avera System Leaders. Infection Preventionist currently participates in monthly LTC Infection Prevention System Calls. Infection Preventionist will participate in Infection Prevention focused webinars, completing 2 annually.	

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F 880	Continued From page 52 appropriate EPA-registered disinfectant at least daily by housekeeping staff and by the caregivers between use by residents 48 and 71. *Disposable plates, cups, and utensils used by resident 48 were expected to have been discarded in the designated garbage receptacle inside of that room. Review of the undated Room Tray Procedure for Passing to COVID Positive Resident policy revealed: *"All disposable products are thrown away in resident room." *"All non-disposable products including tray are bagged from inside room and taken out of room and place on cart outside of room." Review of the undated Terminal Clean of Coronavirus (COVID-19) Rooms policy revealed "If a patient [resident] is in droplet/airborne precautions, housekeeping will clean room on a weekly basis." Review of the revised January 2023 Housekeeping Procedure for Resident Rooms policy revealed daily cleaning expectations included using a germicidal wipe to clean the sink and a disinfection solution to clean the toilet bowl and toilet stool. 3. Observation on 3/22/23 at 10:00 a.m. of a sign taped on the inside of resident 31's door stated that she should have her own E-Z stand mechanical lift body sling. Observation on 3/22/23 from 10:02 a.m. to 10:33 a.m. of CNA J performing morning personal care for resident 31 revealed she: *Entered the room without performing hand hygiene.	F 880		

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F 880	Continued From page 53 *Left the room three times during the observation without performing hand hygiene. *During that time frame she: -Put on a clean pair of gloves without performing hand hygiene and applied lotion to the resident's legs. -Removed the soiled gloves without performing hand hygiene and proceeded to dress the resident. -Partially dressed the resident by putting her socks on, pulling a clean brief and her pants partway up her legs, and then put the resident's shoes on. -Put the E-Z stand mechanical body sling around the resident, positioned her at the side of the bed, and raised her to a standing position with the E-Z stand mechanical lift. -Without performing hand hygiene, CNA J put on clean gloves to remove the residents soiled brief. -With those same gloves, she grabbed a package of wet wipes and cleaned the resident's bottom. -With those same soiled gloves, she applied a skin protection cream to the resident's bottom. -Removed those soiled gloves and without performing hand hygiene, she: --Pulled the residents briefs and pants up. --Touched the buttons on the E-Z stand to lower the resident into her wheelchair. --Removed the sling from behind her and placed the sling onto the E-Z stand. --Wheeled the unsanitized E-Z stand with the sling on it into the hallway. -Without performing hand hygiene, she put on a clean pair of gloves and applied more lotion on the resident's skin before getting the resident fully dressed. -Removed the soiled gloves, without performing hand hygiene, and wheeled the resident out of her room.	F 880		

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F 880	Continued From page 54 -Returned with the resident and proceeded to make the residents bed. *Had not performed hand hygiene during the entire observation. Continued observation on 3/22/23 at 10:33 a.m. of that E-Z stand mechanical lift revealed: *CNA K came and took that E-Z stand mcechanical lift and body sling as described above and went into resident 12's room. *Without cleaning or disinfecting the equipment prior to use or ensuring it had been cleaned and disinfected prior to placement in the hallway, he proceeded to use the E-Z stand mechanical lift and sling for resident 12. 4. Interview on 3/22/23 at 10:36 a.m. with CNA J about her job duties revealed she: *Had been employed for six months. *Agreed she had not performed hand hygiene when leaving or entering the resident's room. *Agreed she should have changed gloves after removing the soiled brief and performed hand hygiene. *Stated they cleaned the E-Z stand and slings between each resident use. -Had not had a chance to clean the E-Z stand and sling before another CNA took the E-Z stand and sling to use for another resident. *She was aware of the notification that resident 31 had her own sling but had not seen one in her room. 5. Interview on 3/22/23 at 1:44 p.m. with CNA K about his job duties revealed he: *Had been a CNA for 32 years. *Was unsure if the E-Z stand and sling he had taken had been cleaned. *Had not cleaned or sanitized the equipment	F 880		

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F 880	Continued From page 55 before using it on resident 12. *Was aware it had to have been cleaned and sanitized between each resident use. 6. Interview on 3/23/23 at 9:21 a.m. with staff development coordinator L about CNA training and job duties revealed: *She was responsible for educating new staff regarding hand hygiene. *Agreed gloves should have been removed and hand hygiene performed after soiled briefs were removed. *Expected staff to clean and sanitize the E-Z stand mechanical lift and the body sling immediately after resident use. 7. Interview on 3/23/23 at 9:31 a.m. with assistant director of nursing/infection prevention nurse C about infection control practices revealed: *They were attempting to get every resident their own body sling. *She agreed that staff should have cleaned and sanitized the equipment between each resident use. *Staff were to follow the "Disinfection of Non-Critical Patient Care Equipment" policy. *Resident 31 had a history of Extended Spectrum Beta-Lactamase (ESBL) in the urine and should have had her own sling. 8. Review of resident 31's electronic medical record revealed in 2018 she had a positive culture of ESBL in her urine. 9. Review of the provider's revised October 2022 "Disinfection of Non-Critical Patient Care Equipment" policy revealed: *I. PURPOSE -"C. For the safety and comfort of residents, all	F 880		

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F 880	Continued From page 56 reusable ("non-critical") resident care items will be cleaned, disinfected, and maintained in a safe manner between residents uses." *II. INFORMATION -"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." --Noncritical resident care items were cleaned between/after each resident use. *III. POLICY -"A. Community/facility items removed from a resident's room need to be disinfected prior to use by a different resident. -D. All reusable resident care equipment removed from a resident room/procedure room is disinfected before use on another resident." -J. Disinfection Recommendations- --1. Reusable resident care equipment. ---a. Between each resident use and when soiled. ----f. lifts 10. Review of the providers revised July 2022 "Hand Hygiene" policy revealed: *"A. HH {Hand Hygiene}, either with soap and water or with alcohol-based hand rub (ABHR): -1. Immediately before touching a resident. -5. After removing gloves."	F 880		

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	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/23/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted from 3/22/23 to 3/23/23. Avera Mother Joseph Manor Retirement Community Building 1 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/24/23. Please mark an F in the completion date column for K241 and K374 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 241		F

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

TITLE
Administrator

(X6) DATE
4/20/23

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

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K 241	Continued From page 1 Based on observation and record review, the provider failed to maintain a one-hour, fire-resistive path of egress from the second level to the exterior of the building. Two randomly observed stair enclosures discharged into the main level corridor system. Findings include: 1. Observation on 3/22/23 at 1:30 p.m. revealed the east and west second-level stair enclosures discharged into the main level corridor system. A one-hour, fire-resistive path of egress was not provided to the exterior of the building. Review of the previous life safety code survey confirmed that finding. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 241		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353	The facility Plant Operations Director will add the 5 year internal sprinkler pipe inspection for dry and wet systems to the preventative maintenance schedule. Western States has been contacted. The inspection will be completed by April 30th. Western States has been contacted and the noted 3 year leak is scheduled to be completed by no later than April 30th. Addendum: Western States completed the inspection on 4/20/23 TS 4/20/23 Sprinkler Inspections Reports will be audited by The Plant Operations Director upon receipt for recommendations and scheduling of needed services. Audit Reports will be reported quarterly to the QA Committee by the Plant Operations Director Or designee until advised by the committee to discontinue.	4/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(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 353	Continued From page 2 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (internal pipe inspections every five years were not done for either wet or dry systems, and air tightness tests every three years were not done for the dry system). Findings include: 1. Record review on 3/23/23 at 7:00 a.m. revealed the internal pipe inspections had not been performed in the past five years. The wet system internal pipe inspection had last been performed on 8/30/17, and no date was recorded for the dry system, but the sprinkler maintenance report supplied by a contractor noted internal pipe inspection was overdue for the dry system. 2. Record review on 3/23/23 at 7:00 a.m. revealed the air tightness test on the dry sprinkler system had not been performed in the past three years. The last recorded test had been performed on 8/30/17. Interview with the maintenance supervisor at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		
K 374	Subdivision of Building Spaces - Smoke Barrie	K 374		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(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 374 SS=C	Continued From page 3 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, measurement, and record review, the provider failed to maintain at least 32 inches of clear width for one set of randomly observed smoke barrier doors (between the 1961 original building and the 1980 addition) opening. Findings include: 1. Observation on 3/22/23 at 12:45 p.m. revealed the cross-corridor doors from the 1961 original building and the 1980 addition measured 30 inches in clear width. Review of the previous survey report revealed those doors were part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 374		

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
	435042	A. BUILDING 2A - SOUTHWEST WING B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted from 3/22/23 to 3/23/23. Avera Mother Joseph Manor Retirement Community Building 2A 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 upon correction of deficiency identified at K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	The facility Plant Operations Director will add the 5 year internal sprinkler pipe inspection for dry and wet systems to the preventative maintenance schedule. Western States has been contacted. The Inspection will be completed by April 30th. Western States has been contacted and the noted 3 year leak is scheduled to be completed by no later than April 30th. Addendum: Western States completed the inspection on 4/20/23 TS 4/21/23 Sprinkler Inspections Reports will be audited by The Plant Operations Director upon receipt for recommendations and scheduling of needed services. Audit Reports will be reported quarterly to the QA Committee by the Plant Operations Director Or designee until advised by the committee to discontinue.	4/21/2023

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

TITLE
Administrator

(X6) DATE
4/20/21

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
	435042	A. BUILDING 2A - SOUTHWEST WING B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(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 353	Continued From page 1 by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (internal pipe inspections every five years were not done for either wet or dry systems, and air tightness tests every three years were not done for the dry system). Findings include: 1. Record review on 3/23/23 at 7:00 a.m. revealed the internal pipe inspection had not been performed in the past five years. The wet system internal pipe inspection had last been performed on 8/30/17. No date was recorded for the last internal inspection of the dry system, but the sprinkler maintenance report noted it was overdue. 2. Record review on 3/23/23 at 7:00 a.m. revealed the air tightness test on the dry sprinkler system had not been performed in the past three years. The last recorded test had been performed on 8/30/17. Interview with the maintenance supervisor at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		

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
	435042	A. BUILDING 3A - NORTHWEST WING B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted from 3/22/23 to 3/23/23. Avera Mother Joseph Manor Retirement Community Building 3A 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 upon correction of deficiency identified at K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	The facility Plant Operations Director will add the 5 year internal sprinkler pipe inspection for dry and wet systems to the preventative maintenance schedule. Western States has been contacted. The inspection will be completed by April 30th. Western States has been contacted and the noted 3 year leak is scheduled to be completed by no later than April 30th. Addendum: Western States completed the inspection on 4/20/23 TS 4/20/23 Sprinkler Inspections Reports will be audited by The Plant Operations Director upon receipt for recommendations and scheduling of needed services. Audit Reports will be reported quarterly to the QA Committee by the Plant Operations Director Or designee until advised by the committee to discontinue.	4/21/2023

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

TITLE
Administrator

(X6) DATE
4/20/23

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING 3A - NORTHWEST WING B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(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 353	Continued From page 1 by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (internal pipe inspections every five years were not done for either wet or dry systems, and air tightness tests every three years were not done for the dry system). Findings include: 1. Record review on 3/23/23 at 7:00 a.m. revealed the internal pipe inspection had not been performed in the past five years. The wet system internal pipe inspection had last been performed on 8/30/17. No date was recorded for the last internal inspection of the dry system, but the sprinkler maintenance report noted it was overdue. 2. Record review on 3/23/23 at 7:00 a.m. revealed the air tightness test on the dry sprinkler system had not been performed in the past three years. The last recorded test had been performed on 8/30/17. Interview with the maintenance supervisor at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		

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
	435042	A. BUILDING _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 3/21/23 through 3/23/23. Avera Mother Joseph Manor Retirement Community was found in compliance.	E 000		4/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Snyder
TITLE: Administrator
(X6) DATE: 4/14/2023

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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
	10590	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COM	1002 N JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/21/23 through 3/23/23. Avera Mother Joseph Manor Retirement Community was found in compliance.	S 000		04/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Snyder — TITLE: Administrator — (X6) DATE: 4/14/2023

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