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	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Mother Joseph Manor Retirement Community	1002 North Jay Street Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, document review, and interview, the provider failed to ensure the posted nurse staffing information included the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per shift, and that the form was posted daily.Findings include:1. Observation on 10/2/25 at 10:00 a.m. of the provider's nursing services staff posting revealed the number of nursing staff working was listed, but not the number of hours they worked was not included.2. Interview on 10/2/25 at 11:12 a.m. with registered nurse (RN) health unit coordinator F revealed:*She was responsible for posting the nursing services staff form.*She was not aware of the requirement that the posting was to include the number of hours worked by nursing services staff, including the RN, LPN, and CNAs.*She posted the nursing services staff form daily when she worked, so it was not completed when she was gone, on weekends, or on holidays.3. A policy that addressed the nursing staff posting was requested, but according to administrator A, the facility did not have a policy regarding that.

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.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, document review, interview, and policy review, the provider failed to:*Ensure appropriate hand hygiene was performed by six dietary staff (K, T, U, BB, and CC) to meet professional food cleanliness standards.*Maintain three of three dishwashers and three of three sanitation solution containers in a manner that met professional food service sanitation standards.Findings include:1. Interview on 9/29/25 at 4:32 p.m. with resident 67 revealed she:*Preferred to eat her meals in her room.*Stated her food was often cold when she received it in her room.*Told the kitchen staff that her food was often cold, but no one had followed up with her regarding that concern, and her food continued to be delivered to her cold.2. Review of the provider's 2025 monthly resident council meeting minutes revealed:*At the 2/19/25 resident council meeting an identified concern was that the Scalloped potatoes are never done*At the 6/18/25 resident council meeting an identified concerns was that the Food temps [temperatures] need to be hotter-The response to this concern was that a plate warmer and another food warmer was being ordered.3. Interview on 9/29/25 at 4:04 p.m. with resident 53 revealed:*She ate in the dining room.*The food was sometimes cold when it was served to her, and it sat in the window for a while before it was served by the staff.*Sometimes the noodles were hard, and the meat was difficult to eat. *She thought the kitchen was short of help.A review of resident 55's electronic medical record (EMR) revealed her 9/15/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. 4. Observation on 9/29/25 in the kitchen revealed:*At 4:55 p.m., cook U did not wash his hands before he put on gloves and poured drinks into glasses for the room trays and left them on a cart, uncovered.*At 5:00 p.m. cook U moved food and soup cans from the warmer into the steam table. *At 5:01 p.m., food service worker BB, did not wash his hands before he put on gloves and, then cut strawberries while holding them in his hand. *At 5:02 p.m., hospitality services manager K took off her gloves, did not wash her hands, gathered containers of prepared food, removed utensils from a drawer, and then scooped food into another container and saran-wrapped sandwiches, with her bare, unwashed hands.*At 5:20 p.m., cook U did not wash his hands and took the temperature of the brats, broccoli, and the beans before he plated meals for the residents' room trays.*He did not check the temperature of the pork chops, which was an alternate food choice, or the pureed foods. *At 5:34 p.m., just before serving the residents' room trays, surveyors requested food service worker GG to check the temperature of the soup and milk. -The temperature of the chocolate milk was 50.6 degrees Fahrenheit (F), and the chicken noodle soup was 96.9 degrees F. -Food service worker GG was unsure what temperature the milk should have been, but stated she thought it needed to be in the 40s F range. -Hospitality services manager K directed the food service worker GG to dump the warm milk, obtain new milk from the fridge, and to warm up the chicken noodle soup to an appropriate temperature before serving to the resident.*At 5:23 p.m., cook U washed his hands, dried them off on his pants, and then put food containers in the steamer.*At 5:34 p.m., just before serving the residents' room trays, surveyors requested food service worker GG to check the temperature of the soup and milk. -The temperature of the chocolate milk was 50.6 degrees Fahrenheit (F), and the chicken noodle soup was 96.9 degrees F. -Food service worker GG was unsure what temperature the milk should have been, but stated she thought it needed to be in the 40s F range. -Hospitality services manager K directed the food service worker GG to dump the warm milk, obtain new milk from the fridge, and to warm up the chicken noodle soup to an appropriate temperature before serving to the resident.*At 5:38 p.m., cook U pushed his glasses up on his nose frequently while plating residents' meals and did not wash his hands. *At 5:38 p.m., cook U opened the tomato and chicken noodle soup cans, checked the temperature of the soups, and stated, It did not meet temp. -He was not sure what temperature the soups needed to be to be safe to serve. -Hospitality services manager K warmed up the soup, rechecked the temperatures and it was above (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	135 degrees F.*At 6:06 p.m., before cook U plated the pureed foods, surveyors requested him to check the temperature of those foods. The pureed meat was chicken, and it was 114 degrees F. The pureed broccoli was 118 degrees F.-He was unsure what temperature those foods needed to be.-Hospitality services manager K warmed up the food so it was above 135 degrees F.*At 6:11 p.m., before cook U plated a pork chop, surveyors requested and had him take the temperature of the pork chops. The pork chops' temperature was 109 degrees F. -Hospitality services manager K warmed up the pork chop to above 135 degrees F.5. Interview on 9/30/25 at 9:06 a.m. with resident 55 revealed:*She ate in the dining room.*She felt the hot food was sometimes served cold, and the milk was sometimes served warm. A review of resident 55's electronic medical record (EMR) revealed her 8/15/25 BIMS assessment score was 15, which indicated her cognition was intact.6. Observation on 9/30/25 in the kitchen revealed:*At 11:04 a.m., food service worker W took her gloves off, did not wash her hands, touched her hands on her glasses and pants, and then pureed (blended to a smooth consistency) angel food cake in a blender.*At 11:14 a.m., hospitality services manager K touched her glasses, did not wash her hands, took bowls of food out of the warmer, checked the temperature of the food in those bowls, and placed them back into the warmer.*At 11:20 a.m., cook T finished wiping the counters with a wash rag, did not wash her hands, opened a bag of dinner rolls, put on gloves, took the dinner rolls out of the bag, put them into a container, removed food containers from the warmer, checked the temperature of the food from the warmer, and then put the containers of food back into the warmer.*At 11:21 a.m., cook CC took his gloves off, did not wash his hands, wiped his nose on his forearm, and put clean dishes away. *At 11:39 a.m. hospitality services manager K took the food out of the warmer, which was at the appropriate temperature, and placed it in the steam table to serve.*At 11:42 a.m., hospitality services manager K, did not wash her hands, plated residents' food for residents' room trays, touched her glasses, and continued to plate food for residents in the main dining room while touching her glasses many times without washing her hands.*Hospitality services manager K started to serve residents lunch in the main kitchen at 11:48 a.m.*At 12:17 a.m., without checking the food's temperature, she started to serve pureed noodles, meat, and cauliflower.-The meat temperature was at 140 degrees, the noodles at 136 degrees, and the cauliflower was at 129 degrees.-She thought the food needed to be between 140-145 degrees, so she rewarmed all the food before serving it to the residents.-Those food items were in an uncovered bowl that was in a shallow pan on the steam table, which was covered with a metal lid.7. Review of the August 2025- September 2025 food temperature logs revealed:*For the Dakota dining room:-From 8/1/25-8/29/25 holding (before serving) food temperatures were not documented eighteen times that month.-From 9/22/25-9/30/25 holding food temperatures were not documented five times.-The following did not meet the required holding temperature of 135 degrees, per the food service code:- On 9/26/25 at dinner time, the cauliflower was 116 degrees, the fish-herb and lemon was 116 degrees, and the mashed potatoes were 131 degrees.-On 9/28/25 at dinner, the meat lovers pizza was 120 degrees.-On 9/29/25 at dinner, broccoli with cheese sauce was 125 degrees, and the pork roast with noodles and sauce was 105 degrees.-No corrective action was documented for any of the above low food holding temperatures.*For the main dining room:-From 8/1/25-8/31/25 the cooking temperatures were not documented 36 times.-From 8/1/25-8/31/25 the holding temperatures were not documented 63 times.-From 9/13/25-9/30/25 the cooking temperatures were not documented 23 times.-From 9/13/25-9/30/25 the holding temperatures were not documented 37 times.-On 9/28/25 at dinner, the vegetable blend was 116 degrees.-There was no documentation of corrective action taken for the low food temperature.8. Review of the provider's May 2025-September 2025 dishwasher temperature and sanitizing solution logs on the Cedar wing revealed:*The Quaternary and Water Temperature Monitoring Form indicated the test strip results should be between 200-400 parts per million (ppm) and the water temperature should be between 65-85 degrees.*The May 2025, June 2025, and July 2025 sanitation solution logs were not provided for review.*The sanitation solution was not documented as checked 119 times in August 2025 and 62 times in September 2025.*The dishwasher (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature log for August 2025 was not provided for review.*The dishwasher temperatures were not documented 26 times in May 2025, 12 times in June 2025, 8 times in July 2025, and 6 times in September 2025.*The dishwasher wash temperature did not meet the required temperature on 6/22/25, 7/6/25, 9/2/25, 9/10/25, 9/14/25, 9/15/25, 9/17/25, 9/24/25, and 9/27/25.*The dishwasher rinse temperature did not meet the required temperature on 6/14/25, 6/16/25, 6/20/25, 6/22/25, 7/3/25, 7/6/25, 7/14/25, 7/19/25, 7/21/25, 7/22/25, 7/25/25, 9/2/25, 9/3/25, 9/4/25, 9/10/25, 9/12/25, 9/13/25, 9/14/25, 9/15/25, 9/17/25, 9/18/25, 9/24/25, 9/26/25, and 9/27/25.-There was no documentation that any corrective action was taken to resolve the temperatures that were out of range.9. Review of the provider's May 2025-September 2025 dishwasher temperature logs and sanitation solution logs on the Dakota wing revealed:*The sanitation solution was not documented as checked 118 times in May 2025, 109 times in June 2025, 120 times in July 2025, 100 times in August 2025, and 88 times in September 2025.*The dishwasher temperatures were not documented 31 times in May 2025, 14 times in June 2025, 11 times in July 2025, 11 times in August 2025, and 18 times in September 2025.*The documented rinse temperatures did not meet the required temperature on 5/28/25 and 5/29/25, 6/12/25, and 6/29/25.-There was no documentation that any corrective action was taken to resolve the temperatures that were out of range.10. Review of the providers' May 2025-September 2025 dishwasher temperature logs and sanitation solution logs for the main kitchen revealed:* Instructions: Dip QUATS test QUAT solution (Not foam surface) for ten (10) seconds, Do not shake; compare colors to color guide at once. Parts Per Million (PPM) must be a minimum of: 300. Record Sanitizer concentration.*The May 2025, June 2025, July 2025, and August 2025 sanitation solution logs were not provided for review.*The sanitation solution was not documented as checked 70 times in September 2025 and did not meet the required sanitation level on 9/19/25 and 9/22/25.-There was no documentation that corrective action was taken to resolve the sanitization level that was out of range.*The dishwasher temperatures were not documented 28 times in May 2025, 22 times in June 2025, 18 times in July 2025, 32 times in August 2025, and 25 times in September 2025.*The dishwasher did not meet the required wash temperature on 5/10/25, 5/22/25, 5/23/25, 6/3/25, 6/16/25 at breakfast and lunch, 6/18/25, 7/5/25, and 8/18/25.*The dishwasher did not meet the required rinse temperature on 5/1/25, 5/5/25, 5/7/25 at breakfast and supper, 5/9/25, 5/10/25, 5/11/25, 5/17/25, 5/18/25, 5/21/25, 5/22/25 at breakfast and lunch, 5/23/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/25, 6/2/25, 6/19/25, 6/22/25, 6/26/25, 6/27/25, 6/28/25, 7/1/25, 7/3/25, 7/6/25, 7/9/25, 7/15/25, 7/17/25, 7/25/25 at breakfast and supper, 8/5/25, 8/6/25, 8/9/25, 8/12/25, 8/14/25 at breakfast, lunch, and supper, 8/16/25, 8/17/25, 8/22/25, 8/25/25, 9/26/25, 9/25/25, and 9/30/25.-There was no documentation that any corrective action was taken to resolve the temperatures that were out of range.11. Interview on 10/1/25 at 8:13 a.m. with food service worker DD revealed:*She took the holding temperature of the food before each meal.*If the food temperature was out of range, she took that food item back to the kitchen to have it reheated.*She would check the temperature of the altered diets, such as pureed food items, before serving them.*She did not check the temperature of the cold foods.* The dishwasher was a high-temp dishwasher.*The wash temperature was to be 160 degrees, and the rinse temperature was to be 180 degrees, and she would notify maintenance if it did not meet those temperatures.*The wash and rinse temperatures were to be documented at breakfast, lunch, and dinner.*Buckets with sanitizer solution were prepared for use at 6:30 a.m., and changed at 11:00 a.m., and before supper.*She was the one to obtain the sanitation solution and was to document the sanitation level each time it was filled.*The sanitizer solution was to be at 300 ppm, and the water was to be at 75 degrees.12. Interview on 10/1/25 at 9:05 a.m. with hospitality services manager K and dietician L revealed:*The hospitality services manager was new in her role, and she started at the end of May 2025.*Providing education to dietary employees who were students was difficult, but she will have the leads (supervisors) help with that and provide more supervision.*The temperature of the food should be checked when it was removed from the oven (cooking temperature) (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and just before serving it (holding temperature) to ensure it was in the safe range.*Food temperatures should be documented on the food temperature logs in the kitchen and each dining room.*If food temperatures were out of range, any staff member was to let the kitchen staff know and bring it back to a safe temperature before serving it. Corrective active steps taken to correct the food temperature should have been documented on the food temperature log, and it was not.*They did not monitor the temperatures of cold foods or the cold drinks.*They acknowledged the warm milk temperature of 50.6 degrees F was not a safe temperature for serving and was considered a potentially hazardous food.*They agreed that if the food temperatures were not at safe serving temperatures and dietary staff did not document if interventions were taken on the food temperature log, then the staff may have served those foods to the residents, which may have put the residents at risk for foodborne illness.*They agreed that if food temperatures were not documented, they could not be sure they were at a safe temperature to prevent foodborne illness.*Modified diet food temperatures should have been checked and documented on the logs.*They reviewed the food temperature logs and determined which dining area they were from, since they were not labeled, and verified that some of the dates were missing.*Warming soup while still in the can was something hospitality services manager K learned from another cook, and she will no longer warm it up in the can, as the instructions on the soup can were microwave it by emptying the contents into a microwave-safe bowl or to heat it on the stove by emptying the contents into a small saucepan.*Hospitality services manager K verified she did not check the food temperatures before serving lunch on 9/30/25, and she should have.*The three-compartment sink sanitation level was monitored each time it was changed.*The sanitizer solution in the buckets for each wing's dining room was monitored each time it was changed.*She was not able to find all the sanitation level logs that were requested.*The sanitation solution was to be changed every two to four hours, and as needed if it was dirty.*Staff were to document the sanitation level each time the sanitation solution was changed in the third compartment sink and the buckets.*They verified that staff were not documenting the sanitation solution per policy, and they should have been.*If the sanitation level was out of range, staff were to empty the sanitation solution and retest it.*Sometimes the water did not always function properly when using both the soap and sanitizer solution at the same time.*If the sanitation solutions did not meet the required sanitation level, staff were to put a work order into maintenance so it could be fixed.*They were not able to ensure proper sanitation of the dishes or the wiped surfaces if the sanitation level was not documented as being in the correct range, which could potentially cause residents to be sick.*They expected the dishwasher wash and rinse temperature to be checked and documented at breakfast, lunch, and supper.*The dishwasher temperatures were not always documented and should have been.*She was unable to find all of the dishwasher temperature logs as requested.*They expected the dishwasher wash temperature to reach 165 degrees and the rinse temperature to reach 180 degrees for effective sanitization.*Reviewing policies and log sheets, they verified that the expected dishwasher temperatures did not match.*Hospitality services manager K asked the maintenance supervisor, who said the dishwasher wash temperature was to reach at least 150 degrees. *They verified that not all the documented wash and rinse temperatures met the required temperature to ensure sanitation was achieved.*Maintenance staff were to be notified if the dishwasher wash or rinse temperature did not meet the required temperatures.*There was no documentation that the maintenance staff was notified when the dishwasher did not meet the required temperatures.*They agreed that if the dishwasher temperatures and sanitization solution levels were not checked and documented, they could not ensure effective sanitation of the dishes and equipment used to prepare and serve residents' food, which could make the resident sick.*When asked, hospitality services manager K did not say how often she reviewed at the sanitation solution and dishwasher logs. *They expected handwashing to be performed when staff entered the kitchen, after touching their face, before putting on gloves, after removing gloves, when changing tasks, and when moving from a dirty to a clean task.*They verified, if a staff member dried their hands on their pants, they should wash (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	their hands.13. Review of the providers' September 2025 Food Temperatures policy revealed:* All potentially hazardous food must be kept below 41 degrees.during transportation.14. Review of the providers' May 2024 LTC Food Safety and Sanitation-System Standard Policy revealed:* Food Safety is paramount to prevent food borne illness.For nursing home residents who are older or sick with compromised immune systems, food borne illness is certainly more serious and may even be life threatening.* The food safety/sanitation program is designed to identify, implement, monitor, evaluate, and correct food sanitation procedures from food production to food consumption. All local, state, and federal standards and regulations are followed in order to assure a safe and sanitary food service department.* Responsibilities:-Nutrition Services Director:-Establish and maintain sanitary standards of cleanliness and food handling practices. All Hazard Analysis Critical Control Point (HACCP) procedures are followed.-Provide and document education to employees on personal hygiene, food handling, and sanitation yearly, or as needed.* Ensure proper maintenance, operation and cleaning of all equipment.* Evaluation practices of food handling to meet sanitary standards.* In collaboration with the Infection Prevention Committee, review and update policies and procedures related to infection control.* Documentation of education/training is maintained and monitored by department leader.* Cooked foods must reach the temperature recommended by the Food Service Code.* Hot food is held at a temperature of 140 degrees or above.* Cold foods are held at a temperature of 40 degrees or less.* Anytime a contaminated surface is touched, the gloves must be changed-washing hands after removing the gloves and before putting on a new pair.* Hands must be washed before serving/distributing meals, & or after picking up soiled plates/waste.* Sanitizer buckets are changed when visibly soiled or per manufacturer directions. The sanitizer is checked for proper concentration with test tape (per manufacturers [manufacturer's] direction).*Cloths must be soaking in sanitizer until use, changing solutions every 4 hours to maintain active concentration.* The dishwasher is maintained and operated according to manufacturer's instructions.-1. Hot water dish machines need to run at 155 [degrees] for wash cycle and minimum of 180 [degrees] for rinse cycle. Always follow manufacturer guidelines to ensure appropriate sanitation levels, regardless of what machine is used. Temperature/appopriate sanitation levels are checked & recorded daily.15. Review of the providers' September 2025 Food Handling policy revealed:* Staff were to wash hands prior to preparing, serving and distributing food. 16. Review of the providers' September 2025 Dishwashing policy revealed:* Wash temperature should reach 150 degree F. * Rinse temperature should reach 180 degree F.17. Review of the providers' September 2025 Hand Washing policy revealed:* Staff will use proper handwashing to prevent the spread of pathogens.

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	435042	A. Building B. Wing	12/17/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and policy review, the provider failed to implement an effective grievance process to ensure residents' satisfaction with the resolution of voiced grievances for:*Two of two sampled residents (55 and 76) regarding long call light response times and noise at night.*One of one sampled resident (89) regarding long call light response times and receiving medications late.*One of one sampled resident (67) regarding cold food and menu choices.*One of one sampled resident (90) regarding lost hearing aides. Findings include: 1. Interview on 9/29/25 at 4:21 p.m. with resident 89 revealed: *Resident 89 stated that she felt that one nurse aide had treated her poorly. Resident 89 explained that she went to bed at approximately 8:30 p.m. one evening and, about three hours later, activated her call light to request assistance to use the bathroom. When the nurse aide responded, the aide stated, I just took you. Resident 89 insisted on being taken to the bathroom, and the aide assisted her but commented, I can't be coming in every five minutes. Resident 89 told another nurse aide about it the next day, whom she described as one of my favorites, but she was not offered or asked if she wanted to file a grievance. She declined to identify that staff member. She did not report that incident to any other staff and stated, All of the other staff are great. *Resident 89 was also concerned regarding the timing when she was given her morning nausea medication, Zofran. She stated the medication was consistently administered late in the morning, by which time she was already experiencing nausea and was unable to eat several noon meals as a result. Resident 89 tried to be more insistent to staff about receiving her Zofran earlier, but there was no change to the time the medication was administered. 2. Interview on 9/30/25 at 9:06 a.m. with resident 55 in her room revealed: *She had experienced urine incontinence episodes when waiting long times for staff to respond to her call light. She unsafely took herself to the bathroom, at times, when she felt she had to wait too long for staff to respond to her call light. *She felt staff were loud at night, laughing and joking in the hallway, and her roommate yelled out her name at times, which kept her awake. *She notified the previous director of nursing and registered nurse (RN)/quality and infection prevention supervisor B about long wait times for staff response to her call light and needing to take herself to the bathroom, loud staff and roommate at night, but it was still happening.3. Interview on 9/29/25 at 4:28 p.m. and 10/1/25 at 3:35 p.m. with resident 76 in her room revealed: *She had to wait a while for the staff to answer her call light, especially in the morning. *The resident across the hall hollers and bangs at night, keeping her awake. *She complained to a staff member about the long call light times and the resident across the hall being loud at night, but she was unsure who she told, and it continued to happen. *She was unsure how to file a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Interview on 9/29/25 at 4:32 p.m. with resident 67 revealed she: *Preferred to eat her meals in her room. *Stated her food was often cold when she received it in her room. *Told the kitchen staff that her food was often cold, but no one had followed up with her regarding that concern, and her food continued to be delivered to her cold. Observation and interview on 9/30/25 at 9:03 a.m. with resident 67 in her room revealed she: *Had her breakfast tray on her over-the-bed table. *Was only given water to drink, and she reported she preferred to have milk with her meals. *Did not fill out her menu choice and she was not sure who had. Interview on 10/2/25 at 8:40 a.m. with resident 67 revealed she: *Had not filed a grievance. *Did not know how to file a grievance. *Did not remember being told she could file a grievance or what the process was to file a grievance. 4. Interview on 9/29/25 at 5:21 p.m. with resident 90 revealed she stated that her hearing aid was lost, which she believed occurred yesterday. She reported that staff had looked in her trash and in her recliner for the hearing aide. The resident stated she was not aware of how to file a grievance and had not been offered assistance by anyone to do so. She also reported she was unsure what actions, if any, the facility was taking regarding her lost hearing aid. 5. Interview on 10/1/25 at 8:32 a.m. with certified nursing assistant (CNA) R revealed: *Residents complained about the staff being loud a few months ago, and management talked to the staff about it. *Resident 76 complained to her about the resident across the hall from her (resident 30) being loud at night. 6. Interview on 10/1/25 at 2:45 p.m. with business office coordinator I revealed: *There had been a recent change within the social worker position. *For 2025, the only grievance logs the provider had been from 1/1/25 through 3/31/25. 7. Interview on 10/2/25 at 7:30 a.m. with CNA EE who worked the night shift revealed: *Resident 30 was loud and would wake up the other residents at night. (continued on next page)

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	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She told registered nurse (RN)/quality and infection prevention supervisor B about resident 30 being loud about a week ago, and was told RN/quality and infection prevention supervisor B would get the social worker and licensed practical nurse (LPN)/resident care supervisor J involved. She was unsure if anything had been done about it yet. *Some CNAs were loud at night, and they were told to be quieter by management. She had not heard anything else about that. 8. Interview on 10/2/25 at 8:05 a.m. with CNA Q revealed: *If a resident had a complaint, she would tell the nurse and try to find out the source of the problem. *She did not know how to help the resident file a grievance. *Resident 55 told her about the staff and her roommate being loud at night. CNA Q did not tell anyone about the resident's concerns because she thought the nurses already knew about it. *Resident 30 banged his call light on the bedside table at times. A management staff person talked to him to let him know he was disturbing others, and that behavior decreased for a little while, but he was doing it again. 9. Interview on 10/2/25 at 8:20 a.m. with social worker (SW) G revealed: *If a resident had a complaint, there was a form they could fill out, and she would then review it and log it in the grievance book. -No one had filled out a grievance form that she knew of since she had started at the nursing home. *If a resident told a CNA about a complaint, the CNA should report it to the department that the complaint was about. *If a resident told a nurse about a complaint, the nurse should tell the director of nursing or the administrator. *Morning staff meetings were held to discuss facility happenings (ie. falls and complaints). -She heard in the morning meeting that a resident had yelled and banged on things at night, but she only heard about that once. -She stated that concern was addressed with the resident who was loud and with the residents who complained about it about a month ago, on one of her first days of working at the nursing home. -She was not aware that resident 30's disruptive behavior continued to be an issue. *Resident 55 reported to her that she had not received good personal hygiene care provided by a night CNA. -Administrator A talked to that CNA and resident 55 and SW G thought that resolved the issue. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She did not have any documentation of the resident's grievances being followed up on by other staff. She would document in the resident's chart regarding grievances she followed up on. *She received residents' complaints regarding long call light times a few times, and she talked to that resident. The resident care coordinator, for that resident, was to run a call light report and then talk to the nursing staff regarding long call light wait times. *Complaints brought forward by the resident council were to be brought to the leaders of the department the complaints were about. *If a complaint was received during a care conference, she would notify the leader of the department the complaint was about, so the department lead could follow up with that concern. She documented in the residents when she followed up on grievances. *She was unsure if the morning staff meetings were documented to indicate if residents' grievances or concerns were discussed. 10. Interview on 10/2/25 at 8:38 a.m. with LPN FF revealed: *If a CNA or resident told her a complaint, she would try to solve it, and if she was unable to solve it, she would tell her supervisor. *She was not sure how to file a grievance for a resident. 11. Interview on 10/2/25 at 8:40 a.m. with resident 67 revealed she: *Had not filed a grievance. *Did not know how to file a grievance. *Did not remember being told she could file a grievance or what the process was to file a grievance. 12. Interview on 10/2/25 at 8:54 a.m. with certified nursing assistant (CNA) P revealed: *She had not filed a grievance for a resident. *If a resident had a concern, she would notify her supervisor or the nurse on duty about the resident's concern. *She thought the grievance form was available online and was to be completed if she had an issue with a coworker. *She did not know who the provider's grievance officer was. 13. Interview on 10/2/25 at 9:07 a.m. with registered nurse (RN) E revealed: *She had worked at the facility for three months. *She had not filed a grievance for a resident or a resident representative. (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

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	435042	A. Building B. Wing	12/17/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding the LTC [long term care] facility stay. *The facility grievance process will be overseen by a designated Grievance Official who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations, maintaining the confidentiality of all information associated with grievances, communicate with residents throughout the process to resolution and coordinate with other staff. *The facility will provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service; will provide residents, resident representatives and others information about the mechanisms and procedure to file a grievance; provide a designated individual to oversee the grievance process; provide a planned, systematic mechanism for receiving and promptly acting upon issues expressed by residents and resident representatives and will provide and ongoing system for monitoring and trending grievances and complaints. *The facility will inform residents orally and in writing of their right to make Complaints and Grievances and the process to do so during admission, readmission and the care planning process. The notice shall include: -a. Information on how to file a grievance or complaint -b. Resident right to file grievances orally or in writing -c. Resident right to file grievance anonymously -d. Contact information of the facility designated Grievance Official -e. Reasonable time frame for completing the review of a complaint -f. Resident right to obtain a written decision regarding his or her grievance -g. Contact information of independent entities with who grievances may be filed in each of the various states [the corporation] facility operates in. -h. Additional notices of the facility grievance process will be displayed in prominent locations throughout the facility (Front entrance and Administration). *A grievance or concern can be expressed orally to the Grievance Official, facility staff or in writing using a grievance form. *Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official. *The grievance Officer will maintain a log of all grievances and/or entered into EMR Risk Management Reporting System for a period of 3 [three] years including; -1. Date of the Grievance (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

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	435042	A. Building B. Wing	12/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, call light report review, and policy review the provider failed to ensure prompt staff response to resident call lights for seven of seven residents (30, 34, 45, 55, 71, 73, and 76) who complained of slow responses to call lights.Findings include:1. Interview on 9/29/25 at 4:26 p.m. with resident 71's husband in the hallway revealed: *He turned on his wife's call light when she was incontinent and needed staffs assistance, and it took the staff over 45 minutes to help his wife. *His wife was dependent on the staff to have her incontinence brief changed as she was immobilized. Observation on 9/30/25 at 8:44 a.m. of resident 71 in her room revealed: *She was sitting in a wheelchair, chewing on her clothing protector, and did not verbally respond to questions. Review of resident 71's EMR revealed: *She was admitted [DATE]. *Her 8/15/25 BIMS score was 0, which indicated her cognition was severely impaired. *She had diagnoses of Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), urinary incontinence, and a history of urinary tract infections. 2. Observation and Interview on 9/29/25 at 4:28 p.m. with resident 76 in her room revealed she: *Was sitting in a wheelchair. *Reported she had to wait a while for the staff to answer her call light, especially in the morning. *Missed going for a walk when she had to wait for staff assistance. *Complained to a staff member about the long call light wait times, but she was unsure who she told. Review of resident 76's EMR revealed: *She was admitted on [DATE]. *Her 7/24/25 BIMS score was 15, which indicated her cognition was intact. *She had diagnoses of major depressive disorder (a mental health condition characterized by persistent sadness or a loss of interest in activities, significantly affecting how you feel, think, and act), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable worry and fear about everyday situations), spinal stenosis (a narrowing of the spinal (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

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	435042	A. Building B. Wing	12/17/2025

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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	12/17/2025

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	435042	A. Building B. Wing	12/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Regarding resident 30: - She felt he was not nice to staff, particularly staff of color. -If staff did not answer his call light within three minutes, he would bang his call light on his bedside table. -He did not sleep at night and turned his call light on for snacks, pop, to empty his urinal, and to change his brief. -She told him she could not be there every two minutes to help him. When he was rude to her, she asked him not to talk to her like that, and she told him she would leave his call light on if he talked to her that way. 10. Interview on 10/2/25 at 8:05 a.m. with CNA Q revealed: *Call lights should be answered within 10 minutes. *If a resident's call light was on when she was busy, she would go acknowledge the resident, turn their call light off, and tell them she would be back to help them. 11. Interview on 10/2/25 at 8:20 a.m. with social worker G revealed: *Resident 55 reported to her a few weeks ago that she was having trouble with the care she received from an overnight CNA. Administrator A followed up, and education was provided to that CNA. *She received complaints regarding long call light response times a few times, and she talked to that resident about that. The resident care coordinator, for that resident, would run a call light report and then talk to the staff. 12. Interview on 10/2/25 at 8:46 a.m. with CNA S regarding residents' call lights revealed: *The staff were expected to answer call lights in a timely manner. *She thought a timely manner meant five minutes or less. *She knew the residents' call lights were on longer around mealtimes when the residents that needed assistance with dining were a priority. 13. Interview on 10/2/25 at 9:18 AM with RN/unit coordinator F regarding call lights revealed: *Staff were expected to answer call lights in a timely manner to ensure the residents' needs were being met. *She was unsure if there was an actual expected time frame that would mean in a timely manner. 14. Interview on 10/2/25 at 9:24 a.m. with RN resident care supervisor C regarding residents' call lights revealed: (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She thought an average of ten minutes was the expectation for staff to answer call lights. *The quality and infection prevention supervisor could print out the call light reports, and she would monitor those reports. *the reports were reviewed monthly or if there was a concern from a resident. *Call lights were a priority to ensure they were meeting the residents' needs. 15. Review of the call light alarm report for resident 34 from 9/1/25 through 10/1/25 revealed there were 60 instances where the call light wait time was from 20 minutes up to 1 hour and 33 minutes. 16. Review of the call light alarm report for resident 45 from 9/1/25 through 10/1/25 revealed there were 50 instances where the call light wait time was from 20 minutes up to 2 hour and 5 minutes. 17. Review of the call light alarm report for resident 73 from 9/1/25 through 10/1/25 revealed there were 18 instances where the call light wait time was from 20 minutes up to 52 minutes. 18. Review of the call light alarm report for resident 55 from 9/1/25 through 10/1/25 revealed there were 7 instances where the call light wait time was from 20 minutes up to 35 minutes. 19. Review of the call light alarm report for resident 30 from 9/1/25 through 10/1/25 revealed there were 90 instances where the call light wait time was from 20 minutes up to 1 hour and 5 minutes. 20. Review of the call light alarm report for resident 76 from 9/1/25 through 10/1/25 revealed there were 9 instances where the call light wait time was from 20 minutes up to 50 minutes. 21. Review of the call light alarm report for resident 71 from 9/1/25 through 10/1/25 revealed there were 2 instances where the call light wait time was from 20 minutes up to 52 minutes. 22. Interview on 10/2/25 at 10:35 a.m. with RN/quality and infection prevention supervisor B revealed: *Call light issues were reviewed at the montly quality assurance meetings if a concern was identified by a resident. *The expected time for staff to answer call lights was 10 minutes. *She agreed a call light over 20 minutes was to long for residents to wait for assistance. *All staff were expected to answer call lights to ensure the residents' needs were being met. 23. Interview on 10/2/25 at 10:55 a.m. with administrator A revealed: *She expected staff to answer residents' call lights within ten minutes. *Anyone who could help that resident should answer their call lights. *She expected the nurses to complete call light audits for residents with complaints or concerns (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding long call light times. 24. Review of the provider's 2/2025 revised Call Light policy revealed: *Objective: To respond to patient/resident's requests and needs on a timely basis. *Procedure: 1. Instruct patient/resident upon admission in regards to use of the call light. 2. Answer light promptly. 3. Be courteous when entering room. Ask patient/ resident May I help you? 4. Turn off call light. Avoid duplication of services. 5. Listen to patient/resident's request. Do not make him/her feel that you are too busy to help. 6. Respond to request. If item is not available, or request questionable, get assistance from charge nurse. Return to patient/resident with prompt reply.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to protect the resident's rights and ensure a resident's advance directive code status (an individual's desire to be resuscitated with cardiopulmonary resuscitation (CPR), specific limited interventions, or not resuscitated (DNR) if their heart stopped) wishes were identified accurately on the physician's orders and the care plans for one of 32 sampled resident (55).Findings include:1. Observation on [DATE] at 2:53 p.m. outside of resident 55's room revealed she had a red dot on her name plate on her door.2. Interview and review of resident 55's electronic medical record (EMR) on [DATE] at 4:30 p.m., and on [DATE] at 4:43 p.m. with licensed practical nurse (LPN)/resident care supervisor J revealed:*Residents' code statuses (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) were ordered by their physician.*The residents did not sign code status forms.*If a resident's code status changed, the provider would request an order from the physician to change it. *She looked in resident 55's EMR and determined the resident had a full code status (life sustaining measures if one's heart or breathing stop).*If resident 55 was found not to have a heartbeat, she would perform CPR immediately.*She reviewed resident 55's [DATE] living will and stated that the resident's code status was supposed to be DNR.*She reviewed the resident's physician's orders, and her full code order was ordered on [DATE], upon her admission to the nursing home.*She reviewed the resident's hospital discharge orders from [DATE], and those orders indicated she had a full code status.*She completed resident 55's assessments and care plan upon admission to the nursing home.*She was to verify the resident's code status wishes with the resident when the resident admitted to the nursing home.*She did not have documentation to support that resident 55's code status was reviewed with her to ensure her wishes would have been followed.3. Interview on [DATE] at 8:32 a.m. with certified nursing assistant (CNA) R revealed the red dots on the residents' name plates of their door meant they had full code status. 4. Interview with resident 55 on [DATE] at 3:59 p.m. revealed:*No one talked to her about her code status wishes since she arrived at the nursing home.*She did not want CPR performed if her heart or breathing stopped, and she was upset that she was ordered to have CPR.*She had a living will that stated she did not want CPR, and she signed that document while in the hospital, shortly before she was admitted to the nursing home.5. Further review of resident 55's EMR revealed:*Upon her admission on [DATE], she had orders from her physician for her code status to be full resuscitation, which were entered by licensed practical nurse (LPN)/resident care supervisor J.*Her [DATE] living will stated, If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life-sustaining treatment has been started, stop it, but keep me comfortable and control my pain.*Her living will declaration stated: This is an important legal document., and This living will remains valid and in effect until and unless you revoke it.*Her [DATE] Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact.*Her printed baseline care plan's first page listed her code status as full code, in smaller writing, which was signed on [DATE] by LPN/resident care supervisor J and resident 55.6. Interview on [DATE] at 11:22 a.m. with registered nurse (RN)/quality and infection prevention supervisor B and interim director of nursing (IDON) AA revealed:*The residents' code status wishes were reviewed with the resident and/or family representative, and then they would request an order from the resident's physician that reflected the resident's code status wishes, unless their code status was listed in the resident's admission orders.*The residents did not sign code status forms.*When asked how they ensured they were following the residents' code status wishes and not just the physicians' orders if there was no document signed by the resident or the resident's representative, RN/quality and infection prevention supervisor B stated, the designated staff member was to discuss it with the residents.*IDON AA stated the admitting staff member (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to look at both the physicians' orders and the residents' advance directives upon admission to determine the resident's code status wishes were followed based on the resident's wishes.Review of the provider's [DATE] Advance Care Planning Policy revealed:* The goals of the advance directive policy are to promote human dignity and self-determination, to ensure that patients' advance directives are honored, and to ensure compliance with the Patient Self-Determination Act of 1990.* When an advance directive document is provided to the facility.an active problem list item Advance care planning is created and a permanent comment is entered that states the type of document.* Advance care planning allows the resident to consider and express their values, goals and wishes regarding care and treatment.Review of the provider's undated Nursing Facility admission Handbook and Resident Care Policies revealed:*During the admission process all new residents will be presented with information regarding Code-No Code. This will be explained to the resident, resident representative and all the available family members by the Social Services Department. The resident or the resident representative must sign the form designating the desired status. The family will be made aware of the fact that the physician must be in agreement with this decision before an order is written.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed respiratory professional standards for:*The clean storage of nasal cannulas (flexible tubing with prongs that delivers oxygen through the nose) for three of three sampled residents (5, 50, and 90) who used them.*The cleaning and storage of nebulizer masks (a mask worn when using a nebulizer machine that converts liquid medication into an inhalable mist) for three of three observed sampled residents (5, 42, and 63) who used them.*The cleaning of Continuous Positive Airway Pressure (CPAP) machines (a device that uses air pressure to keep breathing airways open) for two of two observed sampled resident (5 and 90) who had CPAP machines in their rooms.Findings include: 1. Observation and interview on 9/29/25 at 4:05 p.m. with resident 63 revealed that she was seated in a recliner in her room. Her right hand was contracted, and she was unable to move the fingers of her left hand. A nebulizer machine was on the bedside table, with liquid in the medicine chamber, approximately three-fourths full. Resident 63 stated that nursing staff assisted her with the nebulizer treatments, as she was unable to physically operate the machine independently. The nebulizer had liquid remaining in it, which indicated the nebulizer was not disassembled, cleaned, and left to air dry prior to reassembling it. Review of resident 63's electronic medical record (EMR) revealed she was admitted on [DATE]. Her 7/31/25 Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. 2. Observation on 9/29/25 at 2:37 p.m., of resident 90's room was revealed the resident was not in the room. An oxygen concentrator (a device that filters room air into purified oxygen) was on and set at two liters (L) per minute. The tubing and nasal cannula was draped over the top of the concentrator. A CPAP machine was on the bedside table. The CPAP machine had a reservoir that was approximately three-fourths full of a clear liquid that appeared to be water. Condensation was visible on the top half of the reservoir. 3. Observation and interview on 9/29/25 at 5:21 p.m. with resident 90 revealed: *She did not use her CPAP machine because she used oxygen at night instead. *A CPAP machine was on her bedside table. The water reservoir was about three-fourths full of clear liquid, with condensation on the top half. The tubing had a blue connector that allowed oxygen to be added to the CPAP. *Resident 90 said she was unaware that the machine could be used with oxygen. The oxygen concentrator flow rate was set at two liters and turned on, with the tubing and nasal cannula draped over the top. The improper storage of the nasal cannula posed a risk of contamination, which then would have been transferred into resident 90's nasal passage when it was placed in her nose. Resident 90 stated that the concentrator was always left on, even when she was not using it. She said she had asked the staff to turn it off, but they told her it needed to always remain on. Review of resident 90's EMR revealed her admission date was 9/17/25. Her 9/30/25 BIMS assessment score was a 13, which indicated her cognition was intact. (continued on next page)

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	435042	A. Building B. Wing	12/17/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Observation on 9/29/25 at 3:00 p.m. of resident 50's room revealed: *The resident was not in his room. An oxygen concentrator at the foot of his bed and was turned on. *The nasal cannula and tubing attached to the oxygen concentrator was draped over resident 50's unmade bed. 5. Observation on 9/29/25 at 4:25 p.m. of resident 50 in his room revealed him sitting in a wheelchair beside his bed wearing the nasal cannula. 6. Observation on 10/2/25 at 8:37 a.m. of resident 50's room revealed his nasal cannula and tubing was lying on the floor behind his oxygen concentrator. 7. Observation on 10/2/25 at 10:13 a.m. of resident 50 in his room revealed him sitting in his wheelchair beside his bed, wearing a nasal cannula. Review of resident 50's EMR revealed: *He was admitted on [DATE]. *His 8/1/25 BIMS assessment score was 6, which indicated his cognition was severely impaired. *His diagnoses included respiratory failure (a condition when the lungs cannot properly exchange gasses resulting in abnormal levels of carbon dioxide). 8. Observation and interview on 9/30/25 at 11:18 a.m. with resident 5 in her room revealed: *She was seated in a recliner. A nebulizer machine was on the bedside table next to the recliner. The nebulizer mask had a hazy appearance and appeared to have residue on it. Resident 5 stated that a staff member would place the nebulizer mask on her face at the start of the treatment, and she would remove it and place it on the table when the treatment was completed. *A CPAP machine was on a small dresser. The water reservoir of the CPAP appeared to be dry. Resident 5 stated that she did not use the CPAP machine because she needed water in the reservoir, as her mouth and throat became too dry without it. She said that the night staff would not assist her with filling the water reservoir and told her that she did not need water in it. *There was an oxygen tubing and a nasal cannula stored on top of a puzzle that was on a card table. Resident 5 stated that the cannula and tubing were used for her portable oxygen concentrator. The placement of the nasal cannula on the puzzle posed a risk for the nasal cannula to become soiled. When the nasal cannula was later placed in resident 5's nose she would be exposed to the soiled nasal cannula. Review of resident 5's EMR revealed she was admitted on [DATE]. Her 7/29/25 BIMS assessment score was a 15, indicating her cognition was intact. 9. Observation on 9/29/25 at 3:06 p.m. of resident 42's room revealed: *There was a nebulizer machine with an assembled nebulizer administration set (the cup and mouth (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	piece or mask attached the nebulizer machine to hold and dispense the inhaled medication) on his bedside table. *There were clear liquid drops inside of the nebulizer administration set. Observation on 9/30/25 at 8:00 a.m. of resident 42's room revealed: *The assembled nebulizer administration set was on the side of his nebulizer machine. *There was a small amount of clear liquid inside the nebulizer administration set. 10. Observation and interview on 9/30/25 at 2:05 p.m. with resident 42 in his room revealed: *He administered his nebulizer medication after the nurse placed medication in the nebulizer administration set. *Once the nebulizer treatment was completed, he would place the nebulizer administration set on the side of the nebulizer machine. *He stated licensed practical nurse (LPN) M would come back after he finished his nebulizer treatment, and she would rinse his nebulizer administration set but some of the other nurses did not. 11. Observation and interview on 10/2/25 at 9:01 a.m. with resident 42 in his room revealed: *The nebulizer administration set was on the side of his nebulizer machine. *The nebulizer administration set had clear liquid drops inside the medication chamber and mouthpiece. *Resident 42 stated his nebulizer administration set was cleaned last night, but it was not cleaned after his morning nebulizer treatment, which he received around 7:00 a.m. that day. Review of resident 42's EMR revealed he: *Was admitted on [DATE]. *Had a 9/11/25 BIMS assessment score of 15, which indicated he was cognitively intact. *Had a 4/8/25 physician's order for albuterol/ipratropium [a medication used to open the air passages in the lungs to make it easier to breathe] 3 ML [milliliters] neb [nebulizer] [Duoneb] 3 ML INH [inhaled] TID [three times per day]. 12. Interview on 10/1/25 at 1:39 p.m. with registered nurse (RN)/quality and infection prevention supervisor B revealed: *Nebulizer administration sets were to be disassembled, rinsed with sterile water or distilled water, and placed on a towel to air dry after each use by the nurse or certified medication aide. *Nebulizer administration sets were to be washed with soap and water every night at bedtime. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Nebulizer administration sets were to be replaced weekly and as needed if they became soiled. *Nasal cannulas were to be stored in the plastic bag attached to the resident's oxygen concentrators when not in use to prevent contamination of the nasal cannula. *She expected oxygen concentrators to be turned off when they were not in use. *She agreed that a nasal cannula draped over a resident's bed or on the floor had the potential of having become contaminated and should have been replaced. 13. Interview on 10/2/25 at 8:59 a.m. with certified nursing assistant (CNA) P revealed: *Nasal cannulas were to be rolled up and placed in the plastic bag on the resident's oxygen concentrator when it was not in use. *Staff were to assist resident 50 with his nasal cannula and to turn his oxygen concentrator on and off. 14. Interview on 10/2/25 at 9:04 a.m. with RN E revealed: *Nebulizer administration sets were to be rinsed after the administration of the nebulizer medication was completed by the nurse or certified medication aide. *Nasal cannulas were to be stored in the plastic bag attached to the resident's oxygen concentrator when it was not in use. *Resident 42 would turn off his nebulizer once he completed his nebulizer treatment and place the nebulizer administration set on the side of the nebulizer machine. *RN E would return to resident 42's room later in the morning, disassemble his nebulizer administration set, rinse it, and place it on a towel to dry. *Resident 50 was not able to turn his oxygen concentrator on or off or to put his nasal cannula on, remove it, and store it without staff assistance. 15. Review of the provider's 5/22/25 Respiratory Equipment Care policy revealed: *CPAP/BIPAP -1. Clean according to manufacturer's instructions for use (MIFU) if available. If no MIFU is available: -2. Daily – wipe out the mask with a clean wash cloth [washcloth] and empty water chamber -3 Weekly – a. soak mask and head gear with mild soap and water for 30 minutes, wash, rinse and air dry *Nebulizers (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1. Clean according to manufacturer's instructions for use (MIFU) if available. If no MIFU is available: -2. Rinse after every treatment a. Empty excess fluid b. Rinse nebulizer with sterile (preferred) or distilled water c. shake off excess moisture d. Store --i. place on a clean, dry paper towel (change the paper towel after each treatment) and store in a clean, dry location in the resident's room to air dry for the next treatment OR --ii. in a designated vented respiratory bag that is changed weekly. -3. Daily, or more often when visibly soiled, disassemble and wash with soap and water, rinse and air dry as above. -5. Discard and replace with new Nebulizer set if grossly contaminated with the patient's secretions, it malfunctions, or is dropped on the floor. Review of the provider's December 2024 Oxygen Therapy policy revealed: *Oxygen is administered to residents per physician order. *Procedure for use of concentrators: -Procedure for cleaning and maintenance of concentrator: --Filters are washed weekly with tubing change. --Humidifier jars are changed weekly when used. --Cannula and tubing are changed weekly. --The above procedures will be documented weekly in the EMR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure standard infection prevention practices were followed by:*Two of two certified nursing assistants (CNA) (R and Y) and 1 of 1 registered nurses (RN) (Z) removed their gloves prior to entering the hallway.*Two of two CNAs (R and Y) and one of one RN (Z) performed hand hygiene (handwashing) prior to the application and after the removal of gloves for one of one residents (51).*One of one CNA (R) who used a phone with soiled gloves while in one of one sampled resident's (51) room who was on enhanced barrier precautions (glove and gown use) after assisting that resident with personal hygiene. Findings include:1. Observation on 9/30/25 at 9:18 a.m. in the [NAME] hallway revealed: *CNA Y exited a resident room with a glove on his right hand. *That resident's room had personal protective equipment (such as gowns, gloves, face shield, and masks) (PPE), and a sign posted on the door which indicated a resident who resided in that room was on EBP. *He removed the glove from his right hand and disposed of it in the garbage on the side of the medication cart. *He did not perform hand hygiene after he removed the glove. *Then he opened the doors to three other resident rooms, looked in the rooms, and then closed the doors. 2. Observation and Interview on 9/30/25 at 9:43 a.m. with CNA R in resident 51's room revealed: *Resident 51 was lying in bed, the lights were dimmed, and relaxing music was playing. *Resident 51 would not respond verbally to questions asked. *Resident 51 was on EBP due to having a history of Methicillin-resistant Staphylococcus aureus (MRSA) infection. *Before providing care, CNA R washed her hands and put on a gown and gloves. -She moved the resident's bedding and clothing, then took off her gloves, threw them away, and did not perform hand hygiene. -She put on clean gloves, cleaned the resident's bottom with a wet wipe, then took off those gloves, threw them in the garbage, and did not perform hand hygiene. -She put clean on clean gloves, washed the resident's perineal area (genitals), took off those gloves, threw them in the garbage, and did not perform hand hygiene. -She put on clean gloves, assisted the resident with brushing her teeth, took off those gloves, threw them in the garbage, and did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She put on clean gloves, washed the resident's face with a washcloth, took a phone out of her pocket, called someone, and asked that person to bring her a clean gown for the resident. -With those same gloved hands, she removed the resident's nasal cannula of oxygen from her nose, applied lotion to the resident's face, took off the resident's gown, applied the resident's deodorant, put a clean gown on the resident, put on her nasal cannula, cleaned the resident's nails, and brushed her hair. -CNA Q entered the room wearing a gown and gloves, and assisted CNA R in repositioning resident 51. -After repositioning resident 51, CNA R took off her gloves, threw them away, and did not perform hand hygiene. -She put on a clean pair of gloves, took a cleaning wipe out of a container, wiped the resident's bedside table off, and then took off her gloves and gown, and threw them in the garbage. -With her ungloved hands, she removed the full garbage bag from the garbage container, replaced it with a new bag, and put the resident's fall mat down on the floor beside her bed. -She then performed hand hygiene and exited the residents' room. *Interview immediately following the above observations with CNA R revealed: *She was to wash her hands before going into a resident's room, before applying gloves, before moving from a clean to dirty task, after removing gloves, and when exiting a resident's room who was on EBP. *She confirmed she had not performed hand hygiene when she moved from a dirty task back to a clean task, when she changed her gloves, and when touching the phone during resident 51's care. 3. Observation on 10/1/25 at 10:59 a.m. of RN Z revealed: *RN Z did not wash her hands and then put on a pair of gloves while in the medication room. *She walked from the medication room to resident 83's room with those same gloves on, opened resident 83's door, and laid out her equipment on resident 83's over the bed table. *RN Z collected blood from resident 83's finger and completed a blood sugar check. *She removed those gloves, threw them in the garbage can while in resident 83's room and did not perform hand hygiene. *RN Z then walked down the hallway to the medication room, put on another pair of gloves without first performing hand hygiene, cleaned the glucometer with a sanitizing wipe, removed those gloves, and then performed hand hygiene. 4. Observation on 10/1/25 at 11:18 of RN Z as she administered a nebulizer (a device that converts liquid medication into an inhalable mist) treatment to resident 49 revealed: (continued on next page)

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	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Mother Joseph Manor Retirement Community	1002 North Jay Street Aberdeen, SD 57401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She did not perform hand hygiene prior to preparing the nebulizer medication and placing the nebulizer mask on resident 49's face. She removed her gloves, performed hand hygiene, and then exited the room. *After the nebulizer medication was administered, without first performed hand hygiene, RN Z put on gloves while at the nurse's station, walked down the hall and entered resident 49's room. She removed the nebulizer mask from resident 49's face, rinsed off the nebulizer mask in the resident's sink, removed her gloves and discarded them in the garbage, and then performed hand hygiene. 5. Interview on 10/1/25 at 1:23 p.m. with RN/quality and infection prevention supervisor B revealed: *She expected no gloves to be worn by staff in the hallways due to staff having to touch potentially contaminated surfaces in order to enter a resident room to provide resident care. *Hand hygiene was to be performed before staff put on gloves and after the gloves were removed. *She stated that RN Z should not have been wearing gloves in the hallway before she checked resident 83's blood sugar and before discontinuing resident 49's nebulizer treatment because she expected the staff to put gloves on in the resident's rooms after performing hand hygiene and prior to performing care. *RN/quality and infection prevention supervisor B stated CNA Y should have removed his gloves and performed hand hygiene before exiting the resident's room. 6. Interview on 10/2/25 at 11:22 a.m. with RN/quality and infection prevention supervisor B and interim director of nursing (IDON) aa revealed: *They expected CNAs to perform hand hygiene before putting gloves on and after taking them off. *Before using the phone, staff should have removed their dirty gloves, performed hand hygiene, used the phone, performed hand hygiene again, and then put gloves on. 7. Review of the providers' May 2025 Gloves-LTC Infection Prevention policy revealed: * Gloves are to be changed between patient contacts and when moving from contaminated to clean tasks for the same patient. * Hand Hygiene is to be completed before putting on gloves and after removing them. 8. Review of the provider's 11/14/24 LTC-Hand Hygiene policy revealed: *HH [Hand hygiene] either with soap and water or with alcohol based hand rub (ABHR): .after removing gloves. 9. Review of the providers October 2024 LTC-Transmission Based Precautions and Enhanced Barrier Precautions revealed: * Transmission of infectious organisms within a healthcare setting requires three elements to be linked: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A source (or reservoir) of infectious organisms -A susceptible host -A means of transmission of the organism. -Interruption of this link in the chair of infection is achieved primarily by.using a barrier (Enhanced Barrier Precautions). * Multidrug Resistant Organism (MDRO): bacteria that are resistant to one or more classes of antimicrobial agents. Examples.MRSA. * Enhanced Barrier Precautions (EBP): use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. *.Facilities will incorporate the use of.Enhanced Barrier Precautions.as indicated for known, suspected or incubating infections, or communicable diseases, and for the protection of residents, visitors, and staff from potential exposure to communicable and transmissible diseases. * Enhanced Barrier Precautions are used during high contact resident care activities for the following residents and should be implemented as facilities are able: -Infection or colonization with an MDRO when contact precautions do not otherwise apply. -.gown and gloves must be used during high contact care activities including (but not limited to) -dressing -providing hygiene -changing briefs.