STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435061	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Brady Health and Rehab	500 S Ohlman Mitchell, SD 57301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on record review, interview, and policy review the provider failed to review with the resident, their representative, or their responsible family member and provide a written summary of the baseline care plan for five of eighteen sampled residents (2, 26, 68, 69, and 71) within 48 hours of their admission. Findings include: 1. Review of resident 26's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *Her diagnoses included acute ischemic left MCA (middle cerebral artery) stroke, with right hemiplegia (paralysis or weakness on one side of the body), aphasia (a communication disorder, dysphagia (difficulty swallowing), depression, anxiety, malnutrition, weakness, and a history of GI (gastrointestinal) bleed. *Her Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated she was severely cognitively impaired. *A care plan intervention of I have difficulty expressing my needs so please anticipate my needs; I usually do not volunteer my needs. *A progress note (PN) on 7/30/24 Baseline CC [care conference] held in resident[s] room with nursing and resident. Resident was able to verbalize fine when asked how she was Current medications and POC [plan of care] reviewed and [a] copy was provided for family and resident on [the] nightstand -That was completed on the fourth day of her stay. *The provider's Plan of Care Participation Agreement was signed unable to sign on 7/30/24. 2. Review of resident 71's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *Her diagnoses included failure to thrive, urinary tract infection with sepsis, pain, compression fracture, and a head injury. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she was cognitively intact. *A PN on 9/16/24 Baseline CC held in resident[s] room with resident, nursing, and ss [social services]. [C]urrent medications and POC reviewed and [a] copy [was provided] to [the] resident . -That was completed on the twenty-fifth day of her stay. *The provider's Plan of Care Participation Agreement was signed on 9/16/24. *A copy of her care plan was requested but the provider was unable to provide a printed copy as the resident had been discharged . 50916 3. Review of resident 68's EMR revealed: *He had been admitted on [DATE]. *He was admitted from home due to a fall. *He was diagnosed with right and left pelvic fractures, weakness, falls, Leukocytosis (high white blood cell count), diabetes mellitus, pulmonary hypertension, and chronic obstructive lung disease. *His Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated he was cognitively intact. *His baseline care plan was signed as completed on 11/11/24. 43021 4. Review of resident 2's EMR revealed: *She had been admitted on [DATE]. *Her diagnoses included congestive heart failure, pneumonia, coronary artery disease, hypertension, diabetes mellitus, and osteoarthritis. *Her BIMS assessment score was 15 which indicated she was cognitively intact. *Her baseline care plan had been completed on 10/13/24. *There was no documentation of her baseline care plan being provided to her or her family. Interview on 12/11/24 at 5:14 p.m. with director of social services (DSS) C revealed there was no documentation that resident 2's baseline care plan was discussed or provided to her. DSS C agreed that the requirement for the baseline care plan to be provided to the resident was not met for this resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of resident 69's EMR revealed: *She had been admitted on [DATE]. *Her diagnoses included hypertension, fibromyalgia, anxiety, and osteoarthritis. *Her BIMS assessment score was 15 which indicated she was cognitively intact. *Her baseline care plan had been completed on 11/14/24. *A social services progress note on 11/18/24 that was signed by DSS C indicated her baseline care conference was held with the resident. *A care plan participation form was signed by resident 69 and DSS C on 11/18/24. Interview on 12/11/24 at 5:14 p.m. with DSS C regarding resident 69's baseline care plan revealed: *Resident 69's baseline care plan was discussed and provided to the resident on 11/18/24. *DSS C agreed the requirement for the baseline care plan to be provided to the resident was not met for this resident. 6. Interview on 12/11/24 at 5:55 p.m. with administrator A and director of nursing (DON) B regarding the requirements for baseline careplans revealed: *The provider used their EMR's comprehensive care plan as their baseline care plan and built upon that care plan to complete the resident's comprehensive care plan. *They agreed they had not provided all of the residents and/or family with the summary of the baseline care plan within 48 hours of admission and that there were residents that had Plan of Care Participation Agreements signed by residents after the second day of admission. *They stated the regulation was not clear on when that baseline summary needed to be provided to the resident and family. Interview on 12/12/24 at 12:45 p.m. with DSS C revealed she would wait three to four days after the resident's admission before giving a copy of the baseline care plan to the resident or their family as a means to check with the resident and family to see how things were going. 7. Review of the provider's 6/5/23 LTC (Long Term Care) Baseline/Comprehensive Care Plans policy revealed: *A baseline care plan will be developed within 48 hours of a resident's admission: -To promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission; . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-To ensure the resident and representative, if applicable are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50916 Based on observation, interview, record review, and policy review the provider failed to maintain the physical, mental, and psychosocial well-being by ensuring staff promptly responded to call lights for two of eighteen sampled residents (1 and 16) who used call lights to alert staff of their assistance needs. Findings include: 1. Observation and interview on 12/10/24 at 9:51 a.m. with resident 1 in her room revealed: *She was seated in her recliner. *Her call light was within her reach. *She stated it had taken staff at least 30-60 minutes go answer her call light at times. *She said she had waited so long that she had been incontinent of bowel and bladder. 2. Observation and interview on 12/10/24 at 10:50 a.m. with resident 16 in her room revealed: *She was seated in her recliner, with her feet elevated. *She had a flat touch call light attached to her recliner that was within her reach. *She needed a total body lift (a mechanical lift and sling used to lift a person's full body) to transfer between surfaces. *She stated it could take staff forever to come to her room when she turned her call light on, and they blame that on the call light not working properly. *She stated there had been instances when she had pushed her call light for over an hour before someone arrived. *She pushed her call light and stated she needed to be put in her wheelchair for lunch. 3. Review of resident 1's call light audit report from 11/2/24 to 12/10/24 revealed: *There were eighty-three call light response wait times over 10 minutes. *There were eighteen call light response wait times over 20 minutes. *There were seven call light response wait times over 30 minutes. *On 11/26/24 at 5:37 a.m. the call light response time was 72 minutes and 39 seconds. 4. Review of resident 16's call light audit report from 11/1/24 to 12/10/24 revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There were one hundred and forty-three call light response wait times over 10 minutes. *There were forty-four call light response wait times over 20 minutes. *There were ten call light response wait times over 30 minutes. *On 11/25/24 at 8:46 a.m. the wait time was 68 minutes and 56 seconds. 5. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated cognitively intact. *She was diagnosed with atrial fibrillation, hypertension, chronic kidney disease stage 4, osteoarthritis, hypothyroidism, and overactive bladder. *She needed staff assistance with transfers. 6. Review of resident 16's EMR revealed: *She was admitted on [DATE]. *Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated cognitively intact. *She needed the assistance of two staff and the use of a total body lift to transfer between surfaces. 7. Interview on 12/12/24 at 8:26 a.m. with director of nursing B regarding call light response revealed: *The goal was for staff to respond to call lights within ten minutes 87% of the time. *All staff were responsible to answer call lights if they could. *She agreed thirty minutes is excessively long for residents to wait for assistance. *They were completing monthly audits on call lights. 8. Review of the providers Call Light Policy updated on 08/24 revealed: *Objective: To respond to patient/resident's requests and needs on a timely basis. *Call light scores are calculated monthly. Goal to answer call lights is within 10 minutes 87% of the time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*If call light is defective, report immediately to maintenance.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50916 Based on Observation, interview, record review, and policy review, the provider failed to correctly administer medication for one of one sampled resident (8) by registered nurse (RN) (E) who did not verify resident had a self-administration medication order for her nebulizer treatment. Findings include: 1. Observation on 12/11/24 at 11:23 a.m. with RN E while administering medications to resident 8 revealed: *She had set up the albuterol/ipratropium (medication for breathing problems) 3 ML(milliliters) nebulizer (neb) treatment and handed the neb tube to resident 8. *She paused the treatment because resident 8 was talking on the phone. *Once the resident was done with her phone call, RN E started the treatment and left the room. *RN E did not monitor resident 8 while she self-administered her neb treatment. 2. Observation and interview immediately following the above observation with RN E regarding self-administration medication orders revealed: *If a resident had a self-administration medication order, it would appear as an intervention on their charting for the nursing staff to check off on. *She verified resident 8 did not have a self-administration medication order on her electronic medical record (EMR). *She verified resident 8 did not have a self-administration medication evaluation completed on her EMR. *A self-administration medication evaluation was to be completed first on a resident then a self-administration medication order was to be obtained. *She agreed resident 8 should not have been left unsupervised while she received her neb treatment. 3. Review of resident 8 EMR revealed: *She was admitted on [DATE]. *Her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She had an order for albuterol/ipratropium 3 ML neb to be taken four times a day. *Her Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated cognitively intact. *A self-administration of medication intervention was entered into the care plan on 12/11/24 at 12:17 p.m. 4. Interview on 12/12/24 at 8:51 a.m. with director of nursing B revealed: *Residents can only self-administer their own medications if they have a self-administration medication order. *If residents do not have a self-administration medication order, then they must be supervised while medications are given. *She agreed RN E should have waited and monitored the neb treatment for resident 8. 5. Interview on 12/12/24 at 9:29 a.m. with resident 8 revealed the staff would set up her neb treatments and then leave the room while she administered the neb treatments. 6. Review of the provider's updated 9/6/23 Self-Administration-of-Medications -System Standard Policy revealed: * .the interdisciplinary team (IDT) will assess the resident to determine if the practice of self-administration of medications is clinically appropriate, safe, and feasible. *A resident may only self-administer medications after the IDT has determined which medications may be safely self-administered. *C. Determination of the residents' ability to self-administer medication by the IDT will be documented in the resident's medical record and on the care plan. The documentation will also include the participation of the resident and resident representative, if applicable, in the assessment and care plan process. *E. A physician's order will be obtained and recorded in the chart. *G. Nurse or medication aide to check with resident each shift for appropriate medication administration.