

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER Avera Prince of Peace		STREET ADDRESS, CITY, STATE, ZIP CODE 4513 South Prince of Peace Place Sioux Falls, SD 57103	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interview, and policy review, the provider failed to ensure a thorough investigation was completed for one of one sampled resident (3) who fell in her bathroom and sustained a femoral (thigh bone) fracture. Findings include: 1. Review of resident 3's electronic medical record (EMR) revealed:*She had an unwitnessed fall on 2/9/25 at 6:05 a.m. while she was in the bathroom.*Her 2/9/25 Care Assessments indicated:-She self-transferred herself from her wheelchair onto the toilet while in the bathroom.-She had stated, I knew I needed to go.-She was standing, trying to pull own pants up at the time of the fall. resident acknowledges she knows she was supposed to use her call light for safety reasons. resident stating her right knee twisted and there is swelling and warmth to that knee.-Her previous fall risk score was a 2, which indicated she was at risk for falls.*Her 7/2/25 care plan indicated:-A safety intervention for a sensor pad (a device that alerts when pressure changes occur to indicate movement) under her at all times when she was in her chair or bed, as she forgets to use her call light.-She was to be transferred with the assistance of one staff member.*Her 2/9/25 hospital records revealed she had a right femoral fracture. Interview on 7/2/25 at 12:55 p.m. with certified nursing assistant (CNA) G revealed:*The CNAs referred to a cheat sheet that had specific information regarding the care needs of residents.*If a resident fell, he would call for a nurse or the nurse supervisor if the nurse was not available to let them know.-He would then write a statement of what he knew about the fall as part of the investigation regarding that fall. Interview on 7/2/25 at 1:15 p.m. with CNA E revealed:*The care needs of residents were reflected in their care plans.*If a resident fell, she would notify the nurse and then obtain the resident's vital signs (measurements of basic body functions, such as blood pressure, pulse, respirations, and temperature). Interview on 7/3/25 at 9:50 a.m. with assistant director of nursing (ADON) C regarding resident 3 revealed:*On 12/31/24, the use of a sensor pad alarm in her chair and bed was added to her care plan.*Sensor pad alarms were plugged into the resident's call light port in the room and alarmed for staff to know when they got up by themselves.*She confirmed resident 3 fell on 2/9/25 and fractured her femur. Interview on 7/3/25 at 9:59 a.m. with ADON B regarding resident 3's fall on 2/9/25 revealed:*Resident 3 had transferred from her wheelchair to the toilet in her bathroom by herself.*She activated her call light after she fell.*ADON B confirmed resident 3 had a sensor alarm that was used in her chair and her bed.-She stated the sensor alarm was not used in resident 3's wheelchair at that time.*She stated the sensor alarms were to be checked by staff routinely that they were working, and that was to be documented in the resident's EMR.-There was no place to document where a sensor alarm was located, such as on the chair or bed.*Resident 3 had been checked on 30 minutes before her fall on 2/9/25.*She stated the provider's investigation for resident 3's fall included:--The sensor alarm documentation was reviewed by her and indicated it had been working on 2/8/25 at 9:30 p.m., 2/9/25 at 2:25 a.m., and 30 minutes before resident 3's fall in the bathroom on 2/9/25 approximately 30 minutes before resident 3's fall. -She confirmed there was no documentation indicating where resident 3 was during those times indicated. -Resident 3's sensor alarm pad was checked after her fall and was working at that time.*She had considered the cause of the fall was resident 3 having attempted to transfer herself without staff assistance, and it had not been investigated further.*She confirmed the investigation of resident 3's 2/9/25 fall had not included:-When or how resident 3 had moved herself into her wheelchair to take herself to the bathroom, as the sensor pad had not activated.-Statements from staff members who were working at the time of that fall. Director of Nursing (DON) A was not available for an interview during the survey. Review of the provider's 10/2024 LTC (Long Term Care) Falls and Accidents-System Standard Policy revealed:*Policy Statement: To provide a systematic approach to fall and accident prevention and monitoring, including identifying and evaluating hazards and risk, individualizing approaches to reduce the risk of falls and accidents, and monitoring for effectiveness of interventions when necessary.*Definitions: Position change alarms: alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in a certain way. Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors. Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.*Resident falls: The fall must be investigated for cause, and reported in the facility quality management system for tracking and monitoring.- Review of individualized, resident-centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment must occur. The plan of care must be updated/modified accordingly *All staff are expected to</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the facility failed to ensure the safe use of a mechanical lift (a mechanical lift and sling used to lift a person's full body) by not having assessed the resident for the appropriate lift sling size to have used for one of one sampled resident (2) who fell from the sling and sustained multiple fractures. 1.Review of the provider's 5/15/25 SD DOH FRI revealed:*Certified nursing assistant (CNA) E and CNA F were transferring resident 2 from his wheelchair to his bed while using a full-body mechanical lift.*Resident 2 fell forward out of the lift sling and landed on his face on the floor.*He was bleeding from his chin and mouth and was transferred to the emergency room for evaluation of the injuries.-His diagnoses from the hospital included a maxillary (jawbone) comminuted fracture (broken in several places) that involved multiple teeth and a chin laceration that required six sutures.*CNA E and CNA F had followed his care plan and the facility policy regarding full-body mechanical lift use.*Staff members were educated on Hoyer [a brand of full-body mechanical lifts] lift use.*His care plan was updated that indicated staff were to use black loops on sling, so resident is in a cradle position vs [versus] a sitting position.*Staff members were educated on that care plan change. Observation on 7/2/25 at 12:50 p.m. of resident 2 in his room revealed:*He was lying in bed, with no cover over him.*He was smiling, but did not verbally respond when spoken to. Interview on 7/2/25 at 12:55 p.m. with CNA G revealed:*The CNAs were provided with a cheat sheet reference that had information regarding the specific care needs of residents listed on it. -Resident 2's care needs on the cheat sheet included that he needed the assistance of two staff members with all of his care.*Resident 2 had recently fallen from a mechanical lift.-The size of the sling used was changed for resident 2 after he fell from the mechanical lift.-He was not certain who had made the decision to use a different-sized sling for resident 2 after he had fallen from the mechanical lift.*Mechanical lift slings had different sizes, they were small, medium, large, extra-large, and bariatric (for individuals who are obese). -Each resident was to have their own lift sling, kept in their room, and it was a visual cue to staff to use a mechanical lift when transferring that resident.*CNAs determined the size of the sling to use with each resident.-To determine the size of sling a resident needed, it was held up beside their body.-There was no sizing of the slings completed by the nurses that he was aware of. Interview on 7/2/25 at 1:15 p.m. with CNA E revealed:*The care needs of residents were to be reflected in their care plans, including the type of mechanical lift they were to use.*The size of the slings used with mechanical lifts were color-coded, and the sling size code could be found attached to the mechanical lifts.*The size of the sling was to be determined by the resident's weight and height, and a nurse was to determine which size sling to use for each resident.-The nurse would tell the CNAs what size of sling to use during the report at shift change.-CNAs would also verbally inform each other which size sling to use for residents.*She was not certain if the size of the sling was included on the resident's care plan for staff to know which size to use.*She was trained when she was hired and annually on how to use full-body and sit-to-stand mechanical lifts for resident transfers.-That training included where to place the straps of the sling on the lift, and how to determine if the sling fit the resident.*Regarding resident 2's fall from the lift on 5/14/25:-She and CNA F were transferring resident 2 from his wheelchair to his bed that day.-They placed him in the lift sling, and checked to ensure the sling was placed appropriately.-She then went to the other side of the lift so she could maneuver it, and pulled the lift, with resident 2 in it, away from the chair.-When the lift was moved, resident 2 flipped, went forward and landed on his face, it happened so fast. She did not recall if he had moved while he was in the sling, which may have caused him to fall.-She stated the sling they used that day was the same one he always used and that it was not a usual sling, it was like a hammock, and He came out of the sling, it was a hammock sling. -He had used that hammock sling since his admission to the facility.*Several nurses came to his room after he fell that day, and he was transported to the hospital for evaluation.*The nurses then changed the type of sling he used.-She said one of the nurses had stated that resident 2 he was never to have used the hammock sling.-She said, We didn't know we weren't supposed to use that [hammock] sling.*After he returned from the hospital, a small-sized sling was used for his transfers with the full-body mechanical lift. Interview on 7/2/25 at 1:35 p.m. with CNA F revealed:*She would refer to the resident's care plan to find out what care needs the resident had.*The type of lift a resident used was to be included in their care plan.-The type of sling a resident used with the lift was not always reflected in the resident's care plan.*She would find out what type of sling a resident used during the change of shift report, or she would ask a nurse *At the time</p>		