STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Prince of Peace	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure that the transfer of one of one sampled resident (1) to another long-term care facility met the requirements. Specifically, the facility did not:*Provide documentation that the transfer was necessary for the resident's welfare and that the facility could no longer meet the resident's needs.*Demonstrate that the transfer was appropriate because the resident's health had improved sufficiently.*Provide evidence that the health and safety of individuals in the facility were endangered.*Document that the resident had failed to pay for their stay after receiving appropriate notice. Findings include:1. Observation and interview on 11/5/25 at 8:50 a.m. with administrator A during a facility tour revealed:*The facility was licensed for 126 beds, and 116 residents resided there. Those residents resided in four separate areas.-There was a transitional care area that provided care to residents with ventilators and other complex medical conditions while they were transitioning to other levels of care.-There was a rehabilitation (rehab) area that provided care to residents who received therapy services.-Two other neighborhood areas provided care to residents who required long-term care. 2. Review of resident 1's electronic medical record (EMR) revealed:*He admitted to the facility on [DATE].*His care plan indicated his discharge goal was .to return home upon discharge but [I] understand that I may need a higher level of charge [care] upon discharge.*His care plan interventions included Involve my family in discharge planning.*He was discharged to [facility name], another long-term care facility approximately 75 miles away, on 10/21/25. 3. Interview on 11/5/25 at 2:00 p.m. with resident 1's daughter, who participated by phone, revealed:*On 10/15/25, she was told her father was being discharged from the facility on 10/21/25 to [facility name], a healthcare facility approximately 75 miles away, because he had not made significant progress in therapy, was being discharged from his therapy services, and would not be allowed to stay at the facility. *She thought that her father needed more therapy services and more time to meet his goals.*She wanted to move her father closer to family but felt that she had not been provided enough time or notice to make those arrangements prior to his discharge on [DATE].*She had not been provided with the option to appeal the provider's decision to discharge her father to another long-term care facility. 4. Interview on 11/5/25 at 4:15 p. m. and again on 11/6/25 at 2:46 p.m. with social worker (SW) C revealed:*She completed admission paperwork with resident 1 when he was admitted to the facility on [DATE].*Resident 1 had signed an admission agreement and an admission addendum when he was admitted . -That admission addendum was completed by all residents who were admitted to the rehabilitation area to inform them that their stay would be considered short-term.*She coordinated the discharge planning for all residents who resided in the rehabilitation area of the facility and stated that discharge planning started on the day of admission for all residents.*Resident 1 and his daughters were told on 10/15/25 during a scheduled care conference that resident 1 would be discharged to [facility name], a healthcare facility approximately 75 miles away, on 10/21/25.*Resident 1 had been discharged from the facility because the rehab program was a short-term program; he had not made sufficient progress in therapy, and he could not remain in the facility because he would require long-term care, and another long-term care facility had accepted him to move to their facility. *She had not provided a written discharge notice or information on how to appeal the discharge decision to resident 1, his representative, or the ombudsman regarding resident 1's 10/21/25 discharge.*She was aware that resident 1's daughter was unhappy with the decision to discharge resident 1 to another long-term care facility on 10/21/25.-Resident 1's daughters had not been provided written information about appealing the discharge decision because resident 1 had signed the admission Addendum. She felt that resident 1 signing the admission addendum allowed them to discharge him because he could make his own decisions. 5. On 11/6/25 at 8:42 a.m., administrator A and director of Nursing (DON) B were requested to provide an interview with Social Work Supervisor (SWS) E. SWS E was unavailable during the survey. 6. Interview on 11/6/25 at 9:18 a.m. with registered nurse coordinator (RNC) D regarding the provider's resident discharge process from the rehab area revealed:*Rehab was a separate program at the facility, and the residents who were admitted and resided in that area were not allowed to stay at the facility when their therapy ended.-When discharged from the facility, some residents went home, some moved to independent living or to assisted living, and some went to other long-term care facilities.*The care team, made up of the nursing staff, therapy staff, and social work staff, had determined that resident 1 needed to be discharged from the facility because he required long-term care.*Resident 1 had been discharged to another long-term care provider because he

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to provide a written notice to the resident, the resident's representative, and the Office of the State Long-Term Care Ombudsman at least 30 days prior to the planned transfer for one of one sampled resident (1) who was discharged to another long-term care facility.Findings include:1. Review of resident 1's electronic medical record (EMR) revealed:*He admitted to the facility on [DATE].*His care plan indicated his discharge goal was .to return home upon discharge but [I] understand that I may need a higher level of charge [care] upon discharge.*His care plan interventions included Involve my family in discharge planning.*He was discharged to [facility name], another long-term care facility approximately 75 miles away, on 10/21/25.*There was no documentation of a written notice being provided to the resident, resident's representative, and the Ombudsman. 2. Interview on 11/5/25 at 2:00 p.m. with resident 1's daughter, who participated by phone, revealed:*On 10/15/25, she was told her father was being discharged from the facility on 10/21/25 to [facility name], a healthcare facility approximately 75 miles away, because he had not made significant progress in therapy, was being discharged from his therapy services, and would not be allowed to stay at the facility.*She thought that her father needed more therapy services and more time to meet his goals.*She wanted to move her father closer to family but felt that she had not been provided enough time or notice to make those arrangements prior to his discharge on [DATE].*She had not been provided with a written notice or the option to appeal the provider's decision to discharge her father to another long-term care facility. 3. Interview on 11/5/25 at 4:15 p.m. and again on 11/6/25 at 2:46 p.m. with social worker (SW) C revealed:*She completed admission paperwork with resident 1 when resident 1 was admitted to the facility on [DATE]. Resident 1 signed an admission agreement and an admission addendum that day. *She coordinated the discharge planning for all residents who resided in the rehabilitation area of the facility and stated that discharge planning started on the day of admission for all residents.*Resident 1 and his daughters were told on 10/15/25 during a scheduled care conference that he would be discharged to [facility name], a healthcare facility approximately 75 miles away, on 10/21/25.*She had not provided a written discharge notice or information on how to appeal the discharge notice to resident 1, his representative, or the Office of the State Long-Term Care Ombudsman regarding resident 1's 10/21/25 discharge.*She did not think that resident 1's 10/21/25 discharge required a written 30-day notice.*Resident 1 and his daughters had not been provided information about appealing the discharge from the facility because resident 1 had signed the provider's admission addendum. She felt that resident 1 signing the admission addendum allowed them to discharge him because he could make his own decisions.*She had not provided a notice to the Office of the State Long-Term Care Ombudsman before resident 1 had been discharged .-She provided notifications to the ombudsman once a month through the online system and planned to complete notifications from October 2025 during the week of 11/10/25. 4. Review of the provider's revised January 2024 LTC [Long-Term Care] admission Agreement revealed:*Notice Period When Transfers or Discharges Are Initiated by [the] Facility.- The Facility shall notify the Resident at least thirty (30) days in advance of an involuntary transfer or discharge except when: a. The safety of individuals in the Facility would be endangered. b. The health of individuals in the facility would be endangered. c. The Resident's health improves sufficiently to allow a more immediate transfer or discharge. d. An immediate transfer or discharge is required by the Resident's urgent medical needs. e. The Resident has not resided in the Facility for thirty (30) days.*The Resident will be notified of the right to appeal the transfer or discharge to the state. Review of the provider's revised January 2024 admission Agreement Addendum for Residents admitted to Rehabilitation, Transitional Care, or Ventilator Units indicated:*If we determine that you can be discharged from the Unit, both you and the Resident Representative consent to discharge from the Facility Unit and agree to fully cooperate with the Facility discharge planning staff in conjunction with your discharge. You will receive advance notice of discharge regarding this decision along with a notice of termination of Medicare Part A benefits, if applicable. Review of the provider's revised June 2024 LTC [Long Term Care] Transfer & [and] Discharge policy revealed:*The objective of the transfer/discharge policy is to ensure that the resident is informed of an impending discharge and their right to appeal the discharge. *.The facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. The copy of the notice to the Ombudsman must be sent at the same time the notice is provided to the resident representative