STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST , REDFIELD, South Dakota, 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/25/26 through 1/28/26. Avantara Redfield was found not in compliance with the following requirements: F565, F641, F655, F658, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/25/26 through 1/28/26. Areas surveyed included potential abuse and neglect related to staff not assessing and providing care after a resident fell, and to resident verbal abuse, quality of care and treatment related to bathing, medication administration, and restricting a resident from leaving the facility, and accident hazards related to a resident who started a fire in a microwave..Avantara Redfield was found not in compliance with the following requirement: F565	F0000		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident	F0565		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Forgey	Administrator	2/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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F0565 SS = E	Continued from page 1 or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview, resident council meeting, resident council meeting minutes review, grievance forms review, and policy review, the provider failed to ensure that grievances regarding the food quality of residents' meals were addressed, and documentation reflecting the staff's efforts to resolve those grievances was communicated to the residents and approved as effective resolutions for: *Nine of nine residents (13, 18, 19, 22, 24, 36, 40, 50, and 51) who individually reported concerns in grievance records reviewed from July 2025 through January 2026. *Five of five residents (12, 19, 25, 32, and 44) who attended the resident council meeting on 1/26/26. Findings include: 1. Interview on 1/25/26 at 12:19 p.m. with resident 4 revealed: *He preferred to eat meals in his room. *When his meal trays were delivered to his room, the food was not always as hot as he thought it should be. 2. Interview on 1/26/26 at 8:45 a.m. with resident 41 revealed:	F0565	1.All cooks were educated on food temperatures and the quality and presentation of evening and weekend meals on 2/13/26. The Food Committee will begin meeting weekly on 2/18/26. Two new food delivery carts for room service were ordered on 2/3/26. New bases and covers for room tray service were ordered on 2/4/26. 2.The Administrator or designee will provide education to all staff regarding the Grievance Policy and the Resident Rights-Food and Nutrition Services Department Policy to ensure that grievances regarding the food quality of residents' meals are addressed, and documentation reflects the staff's efforts to resolve those grievances are communicated to the residents and approved as effective resolutions by 2/19/26. Any staff not in attendance will receive the education prior to their next scheduled shift 3.The Administrator or designee will audit 5 random evening and weekend meals and 5 random residents weekly x 4 and monthly x 3 to ensure that grievances regarding the food quality of resident's meals are addressed, and documented reflecting the staff's efforts to resolve those grievances were communicated to the residents and approved as effective resolutions. Results of the audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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F0565 SS = E	Continued from page 2 *He preferred to eat meals in his room. *When his meal trays were delivered to his room, the food was not always as hot as he thought it should be. *He stated he was served burnt French Toast for a morning meal. 3. A resident council meeting held on 1/26/26 at 1:01 p.m. revealed: *The resident council had a president, and they met monthly to discuss their concerns. *Residents 12, 19, 25, 32, and 44 voiced complaints that their concerns regarding their meals and the food quality, which were communicated during previous resident council meetings, were not resolved. *They felt their complaints were heard and documented, but there were no solutions or follow-up provided to them. *They felt that they “complained and complained” and that “no one cares.” *Resident 19 stated he heard there was a new cook, but the quality of the food had not improved. 4. Review of the provider’s August 2025 through January 2026 resident council meeting minutes revealed: *On 8/4/25, “Mashed potatoes still very watery.” Was the issue resolved to your satisfaction was marked “no,” and “How are they doing?” Dietary was marked “Lots of carbs [carbohydrates].” *On 11/4/25, “Evening food isn’t [is not] good- Bean Soup was to [too] spicy to even eat [on] 11/3/25,” and “Desserts are not very good.” “How are they doing?” Dietary was marked “Days are good, Evenings [are] not good.” *On 12/5/25, “Evening meals are not good.” Was the issue resolved to your satisfaction was marked “no,” and “How are they doing?” Dietary was marked “Weekend & [and] evenings are not good.” *On 1/8/26, “Evening meals are not good.” Was the issue resolved to your satisfaction was marked “no,” and “Evening meals [are] not good. [They] Just throw food	F0565		

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F0565 SS = E	Continued from page 3 together & [we] don't always know what it is." "How are they doing?" Dietary was marked "Evening meals are still not good." 5. Review of the provider's July 2025 through January 2026 grievances revealed: *On 7/8/25, the resident council filed three grievances regarding the dietary meal service and the quality of the food, which indicated that four out of six unnamed residents who attended the resident council meeting shared the concerns. -The provider's "Resident Council Department Response Form" indicated a response was due to the resident council representative within 5 days after they filed a grievance. There was no documentation to indicate "The Department Response: (Includes dates of proposed or completed actions. Describe actions taken and results expected)," or when that "Departmental Response" was "Presented to [the] Resident Council." *On 7/9/25, resident 50's representative filed a grievance indicating, "food not done, tray was a mess." The provider indicated the resolution was a "staff inservice." *On 10/3/25, residents 13 and 40 filed grievances regarding the dietary department not following their diet orders. -The "Resolution" on the Grievance and Satisfaction Form indicated that the dietary manager was re-educated "to follow [the] resident's diet on 10/3/25." *On 12/20/25, residents 18, 19, 22, 24, and 51 filed grievances regarding the dietary department. Their concerns included the timing of the meal delivery, the quality of the food, "not enough food on the plate," "no meat," and the food not having been cooked "as it should be." -The "Resolution" on the Grievance and Satisfaction Form indicated "cook working on 12/20 will be re-educated and trained on proper preparation and serving of food." *On 1/4/26, resident 36 filed a grievance indicating that the "food [was] not done." *On 1/8/26, the resident council filed a grievance regarding the quality and presentation of the food served at their evening meals, which indicated that	F0565		

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F0565 SS = E	Continued from page 4 three out of four unnamed residents who attended the resident council meeting shared those concerns. -The Resident Council Department Response Form indicated “working on plating presentation and seasoning to meals to add a little color.” There was no indication that information was shared with the resident council representative. 6. Interview on 1/28/26 at 8:49 a.m. with activities director (AD) O revealed: *She facilitated the monthly resident council meeting and felt that the residents shared concerns about the quality of the food, the temperature of the food, the taste of the food, and not receiving the planned meals for about eight months. *She completed a Resident Council Department Response Form to document the residents' concerns and gave that form to dietary manager (DM) L and social services coordinator (SSC) Q. -She expected that DM L would complete the “Department Response” section of that form, and AD O would share that information with the residents at the next resident council meeting, but she did not receive the forms back. *The residents seemed frustrated during the resident council meetings because they did not see an improvement in the quality of the food they were served at their meals. Their complaints were mostly about food served to them in the evenings and on the weekends. *She assisted residents in filling out a Grievance and Satisfaction Form if they reported a concern outside of the resident council meeting. *DM L, SSC Q, and administrator A did not attend the resident council meetings. 7. Interview on 1/28/26 at 9:09 a.m. with SSC Q regarding resident grievances revealed: *When she received a grievance from the resident council or a resident, she would provide a copy to the department manager to complete the form, which included the resolution and the notifications. -Those completed forms were to be signed by administrator A, then SSC Q was to log the grievance	F0565		

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F0565 SS = E	Continued from page 5 for tracking purposes. *SSC Q did not communicate the resolution to the resident council or individual residents. -She expected that DM L would discuss concerns regarding the dietary department with the residents and follow up with the residents with resolutions to those concerns. 8. Interview on 1/28/26 at 9:19 a.m. with DM L regarding resident grievances concerning their meals revealed: *She began working at the facility about a month ago. She was aware that the residents shared concerns about the quality of their meals, the temperature of the food served to them, and the dietary department's not following menus or residents' physician-ordered diets or preferences. *She was working on completing the 1/8/26 Resident Council Department Response Form regarding resident council concerns about the quality and presentation of the evening meals. *She spoke with other residents to see if they shared the same concerns, but did not meet with the resident council about their food-related grievances. 9. Interview on 1/28/26 at 9:37 a.m. with administrator A revealed: *She was aware of the residents' concerns about the quality, temperature, and presentation of their meals. *The previous DM's employment with the facility ended approximately three months ago, and she felt that they were working on resident concerns about the food for "quite a while" before he left. *Resident concerns about the food were addressed by providing additional education to the dietary staff members. *She did not attend the resident council meetings, but would if they invited her. *She expected DM L to follow up with residents about their concerns with the food. *She was unsure if SSC Q followed up with residents	F0565		

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F0565 SS = E	Continued from page 6 when she received the completed grievance forms or if she just tracked those forms. *She expected AD O to share the resolution to the resident council grievances with the residents at the next resident council meeting. *She was unaware that the residents did not receive information about the provider's actions being taken to address their food-related grievances. 10. Review of the providers' 5/15/25 Grievances policy revealed: *"It is the policy of this facility to investigate all grievances…" *"The Administrator or designee shall confer with persons involved… and within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party." *"During the investigation, the facility will put in place immediate action to prevent potential violation of resident's rights." *"All written grievance decisions will include… the steps taken to investigate the grievance, a summary of the pertinent findings… any corrective action to be taken by the facility as a result of the grievance…" *"Communicate to[the] customer [the] actions taken and discuss [the] outcomes of this action to determine effectiveness… Ensure Customer satisfaction with outcomes. Follow-up to ensure concern is resolved." 11. Review of the providers' undated Resident Rights -Food and Nutrition Services Department policy revealed, "All dietary requests and concerns should be addressed in a courteous manner. Any request given to a dietary staff member should be promptly addressed. Those concerns that cannot be addressed by the Cook or Dietary Aide should be communicated to the Director of Food and Nutrition Services or other clinically qualified nutrition professional.	F0565		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641		

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F0641 SS = D	Continued from page 7 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of two sampled resident's (25 and 43) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the Pre-Admission Screening and Resident Review (PASRR). Findings include: 1. Review of resident 25's electronic medical record (EMR) revealed:	F0641	1.Resident 25 and 43's assessments were modified on 2/13/26. 2. The Social Services Designee was educated by Licensed Social Worker Consultant on the South Dakota PASRR Level I & Level II PASRR Outcomes on 1/27/26. 3.The Social Services Designee or designee will audit 5 random MDS assessments weekly x 4 and monthly x 3 to ensure the assessment was accurately coded for the PASRR. Results of the audits will be presented by the Social Services Designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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F0641 SS = D	Continued from page 8 *She was admitted on 2/2/23. *Her diagnoses included major depressive disorder, obsessive compulsive disorder (reoccurring thoughts and repetitive behaviors), anxiety disorder (anticipation of future danger or misfortune with symptoms such as restlessness or irritability), and paranoid schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a distorted sense of reality). *Her 5/9/23 level II [2] PASRR which stated, “This PASRR approval is not time limit [does not have a time limit] there is no need to re-submit unless there is a significant change that may impact PASRR status”. *Item A1500 of her 12/20/23, 12/4/24, and 3/31/25 comprehensive MDS assessments were coded “No” to the question “Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?” *Her 1/27/26 care plan had a focus area initiated on 4/11/24 that stated, “PASRR/MH [mental health] LEVEL II NOTICE OF DETERMINATIONThe resident has been screened by the contracted Pre-Admission Screening (PASRR) agency and found to be in need of long-term care placement/services. The resident has a diagnosis of severe persistent mental illness.” 2. Review of resident 43’s EMR revealed: *She was admitted on 10/20/25. *Her diagnoses included delusional disorders (false beliefs and distorted views that are classified as a serious mental health condition). *Her 10/15/25 notice of “PASRR Outcome Explanation”, indicated “The facility should mark yes for question A1500 on the Minimum Data Set”, ‘Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition?’” *Item A1500 of her 10/27/25 comprehensive MDS assessment was coded as “No” to the question: “Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?” *Her 1/28/26 care plan did not indicate she was	F0641		

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F0641 SS = D	Continued from page 9 considered to have a PASRR Level II. 3. Interview and record review on 1/27/26 at 11:59 a.m. with social service coordinator (SSC) Q regarding completing MDS assessment item A1500 revealed: *She was provided with training on how to complete the MDS by a consultant. *She completed A1500 for all residents' comprehensive MDS assessments. *After reviewing resident 25's comprehensive MDS assessments for 12/20/23, 12/4/24, and 3/31/25, she confirmed all of those assessments should have been coded as a "Yes" for item A1500. *After review of resident 43's "PASRR Outcome Explanation" and her comprehensive MDS from 10/27/25 she confirmed item A1500 for resident 43 should have been coded as "yes". 4. Interview on 1/28/26 at 10:48 a.m. with administrator A regarding MDS item A1500 coding for residents 25 and 43 revealed that she expected those MDS assessments to be coded accurately. 5. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed section A, item A1500, revealed "Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition".	F0641		
F0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F0655		

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F0655 SS = E	Continued from page 10 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to develop a person-centered baseline care plan that included the minimum healthcare information necessary to provide care for four of five newly admitted residents (8, 18, 32, and 33) and failed	F0655	1.Residents 8, 18, 32, and 33's baseline care plans are unable to be modified. 2.The Director of Nursing educated all licensed nursing staff on the Baseline care plan policy on 1/25/26 to ensure a person-centered baseline care plan is developed to include the minimum healthcare information necessary to provide care and to ensure the care plan is reviewed with the resident or resident representative within 48 hours of admission. 3. The Director of Nursing or designee will audit all new admissions weekly x 4 and monthly x 3 to ensure the baseline care plans are completed timely and reviewed with the resident or resident representative within 48 hours of admission. Results of the audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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F0655 SS = E	Continued from page 11 to ensure the resident's baseline care plan was reviewed with the resident or resident representative within 48 hours of admission for three of five newly admitted residents (18, 32, and 33). Findings include: 1. Review of resident 32's electronic medical record (EMR) revealed: *She was admitted on 8/4/25. *Resident 32's representative and licensed practical nurse (LPN) G signed her baseline care plan on 8/13/25, nine days after she was admitted to the facility. *Resident 32's 8/4/25 baseline care plan did not indicate the level of assistance he required from staff to complete bathing tasks or what diet he should receive at meal times. -"Resident requires assistance with ADL's [activities of daily living]: bed mobility, transfers, dressing, personal hygiene, eating and toileting." The goal was "Resident will be assisted with ADLs as needed. The intervention was "Assist resident with showering/bathing per schedule." --The baseline care plan did not indicate the level of assistance that resident 32 required to complete bathing tasks. 2. Review of resident 33's EMR revealed: *He was admitted on 9/3/25. *Resident 33 did not have an individualized baseline care plan completed or reviewed with him or his representative within 48 hours of his admission to the facility. 3. Review of resident 8's EMR revealed: *He was admitted on 10/8/25. *His 10/28/25 admission nursing assessment indicated that he was dependent on staff members for bathing, dressing, using the toilet, and eating. *His 10/28/25 baseline- care plan indicated: - "Resident requires assistance with ADL's: bed mobility, transfers, dressing, personal hygiene, eating	F0655		

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F0655 SS = E	Continued from page 12 and toileting." The goal was "Resident will be assisted with ADLs as needed. The interventions were to provide assistance for meals if indicated and to assist resident 8 with showering/bathing per schedule. --The baseline care plan did not indicate that resident 8 was dependent on staff for assistance with eating. --The baseline care plan did not indicate the level of assistance that resident 8 required to complete bathing tasks. -"Assist with application of appliances if needed (hearing aids, eyeglasses, dentures)." -"Make sure that the resident wears eyeglasses and/or hearing aids, if applicable." -"Provide DME [durable medical equipment] if needed (wheelchair, cane, walker, etc)." --The baseline care plan did not indicate which of these that resident 8 used or the level of assistance he required for transferring and mobility. 4. Review of resident 18's EMR revealed: *He was admitted on 12/16/25. *Resident 18 signed his baseline care plan on 12/22/25, six days after he was admitted to the facility. Review of resident 18's baseline care plan revealed: *Resident 18's 12/16/25 baseline care plan did not indicate: -The level of assistance he required to complete bathing tasks. -If he needed hearing aids, glasses, dentures, a wheelchair, a cane, or a walker. -The level of assistance he required to complete bed mobility, transfers, dressing, personal hygiene, eating and toileting." 5. Interview on 1/26/26 at 10:13 a.m. with administrator A revealed resident 33 did not have a baseline care plan that was completed or reviewed with him or his representative. 6. Interview on 1/28/26 at 10:28 a.m. with certified nursing assistant (CNA) K revealed she referred to the	F0655		

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F0655 SS = E	Continued from page 13 resident's Kardex (a report of the resident's care needs and interventions) to determine how to care for a newly admitted resident. -The resident care needs in the Kardex was based off the information in that resident's care plan. 7. Interview on 1/28/26 at 11:18 a.m. with LPN G revealed: *She stated a resident's baseline care plan was to be completed within the first 24 hours of admission and reviewed with the resident or the resident's representative within the first 48 hours after their admission to the facility. *The resident's baseline care plan was documented in a check box format within the admission assessment in the EMR. *After the admission assessment was completed, the nurse would document that information in the resident's care plan to make the baseline care plan. *She stated each resident's baseline care plan should reflect the assistance needs of that resident. 8. Interview on 1/28/26 at 1:13 p.m. with director of nursing (DON) B revealed: *Baseline care plans were to be completed and reviewed with the resident or resident representative within 48 hours of that resident being admitted to the facility. *She expected the baseline care plans to be individualized to include the basic needs to care for that resident, such as how a resident can transfer. 9. Review of the provider's 5/14/25 Care Plan policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"The DON will be responsible for holding the team accountable to initiating and completing the Admission [baseline] care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter." *"Interventions act as the means to meet the individual's needs."	F0655		

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F0655 SS = E	Continued from page 14 *"A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later than 48 hours after admission. Nursing, Dietary, Activities and Social Service staff complete formal assessments, interviews, and observations and begin formulating the full care plan as soon after admission as possible. (These departments do have areas that need to be completed by the 48- hour deadline). *"The areas that must be addressed in the base line care plan include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a) Initial goals based on admission orders. b) Physician orders. c) Dietary orders. d) Therapy services. e) Social services."	F0655		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure staff members followed quality of care practices and professional standards that ensured: *A Roho cushion's (air filled cushion designed for high-level pressure ulcer prevention and treatment) were used and maintained according to manufacturer's instructions for one of one sampled resident (5) with a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) to her buttocks and upper thighs. *Specialized compression garments had complete	F0658	1.On 1/27/26, Circaids discontinued, verbal order received from CNP for ace dressings to feet and legs to be changed twice daily for edema and Nystatin cream to top of right foot bid. MD was notified on 1/28/26 with new order noted: Lay in bed QID, discontinue ROHO cushion and follow up with wound care. 2.The Director of Nursing or designee will educate all licensed nursing staff on the ROHO Cushion operation manual and how to check for air volume, the application and maintenance of specialized compression garments and proper urine specimen collection by 2/19/26. Any staff not in attendance will receive the education prior to their next scheduled shift. 3. The Director of Nursing or designee will audit all ROHO cushions, specialized compression garments and urine specimen collection weekly x 4 and monthly x 3 to ensure staff are following quality of care practices and professional standards. Results of the audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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F0658 SS = E	Continued from page 15 physician's orders for use and were applied according to the manufacturer's instructions for one of one sampled resident (5) with lymphedema (tissue swelling caused by blocked lymph node fluid drainage) who used Circaids (adjustable compression garments designed to treat lymphedema, venous insufficiency, and edema). *A urine sample was collected according to the facility's identified professional standard reference by registered nurse (RN) E for one of one sampled resident (33) who was on an antibiotic for a urinary tract infection (UTI). Findings include: 1. Observation and interview on 1/25/26 at 2:54 p.m. with resident 5 in her room revealed: *She was sitting in her recliner with her feet elevated. *She stated she had an open sore on her right foot, her buttocks and her upper legs. *There was a Roho cushion in her wheelchair that was covered with a pillow and a protective absorbent pad. *Resident 5 stated she put the pillow on top of the Roho cushion when she used it because she did not like sitting on plastic. *The Roho cushion did not have a protective cover on it and the air pockets were flattened. *Resident 5 stated she also had a Roho cushion in her recliner. *That Roho cushion had an absorbent protective pad over it and did not have a protective cover on it. 2. Review of resident 5's electronic medical record (EMR) revealed: *She was admitted on 10/3/22. *Her 11/21/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated her cognition was moderately impaired. *She had a stage III (3; open wound with full-thickness skin loss. Fatty tissue may be visible) pressure ulcer on her left and right buttocks.	F0658		

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F0658 SS = E	Continued from page 16 *Her 1/25/26 care plan stated “ROHO cushion placed in recliner and in w/c [wheelchair]. I prefer a pillow be placed on top of cushion when using it.” 3. Observation and interview on 1/26/26 at 9:32 a.m. of licensed practical nurse (LPN) G and certified medication aide (CMA) H when providing care for resident 5’s pressure ulcer in her room revealed: *LPN G stated resident 5 had a pressure ulcer on her buttocks and her upper thighs. *She had a Roho cushion in her wheelchair and her recliner. *LPN G verified there were no protective covers on resident 5’s Roho cushions. *LPN G stated the staff placed the pillow on top of resident 5’s Roho cushion in her wheelchair because she requested it. *She stated that staff have been educated that the pillow on top of the Roho cushion made the Roho cushion ineffective. *LPN G picked up the Roho cushion in resident 5’s wheelchair and stated it was flat and needed more air put into it to provide support. *She stated she checked resident 5’s Roho cushions for proper inflation on Mondays when she completed resident 5’s skin assessments. *She rolled the Roho cushion up and placed it into a plastic bag and stated she would take it to the therapy department to fill it with air. *LPN G stated the therapy department was responsible for maintaining the residents’ Roho cushions. *When asked if resident 5 used her wheelchair that morning CMA H verified resident 5 was in her wheelchair in the dining room for breakfast. 4. Observation and interview on 1/26/26 at 10:28 a.m. of CMA H and LPN G in resident 5’s room revealed: *LPN H placed the inflated Roho cushion into resident 5’s wheelchair. *There was no protective cover on that Roho cushion. *She did not check that the Roho cushion was	F0658		

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F0658 SS = E	Continued from page 17 sufficiently inflated to provide pressure relief. *She did not check the Roho that was on resident 5's recliner to determine if that was sufficiently inflated to provide pressure relief. *CMA H and LPN G did not remove the absorbent protective pads that covered the Roho cushions in resident 5's recliner or wheelchair. *Resident 5 denied that a staff member told her the pillow and pads make the Roho cushions less effective. *CMA H stated she could not recall ever seeing protective covers on resident 5's Roho cushions. *CMA H stated she did not received any training about Roho cushion use. 5. Interview on 1/27/26 at 8:50 a.m. with administrator A revealed: *The provider did not have a policy related to the use of Roho cushions. *The staff did not receive training related to the maintenance and use of Roho cushions. 6. Interview on 1/28/26 at 9:31 a.m. with physical therapy assistant (PTA) T revealed: *The therapy department would give a resident a Roho cushion to use and monitor it if the resident was receiving therapy services. *Resident 5 was recently referred to therapy, but she had her Roho cushion prior to that. *If a resident was not receiving therapy services and has a Roho cushion the nurses were responsible for monitoring and maintaining it. *PTA T stated Roho cushions should have a protective cover that was designed for use with the Roho cushion. *If the protective cover was not on the Roho cushion it would potentially cause increased moisture exposure to a resident's skin which could cause skin breakdown. *She was aware resident 5 did not have a protective cover on her Roho cushion. *PTA T stated the Roho should not have anything over it other than the protective cover, such as a pillow or an	F0658		

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F0658 SS = E	Continued from page 18 absorbent protective pad, because that would interfere with the functionality of the Roho cushion. 7. Interview on 1/28/26 at 10:28 a.m. with CNA K revealed: *She stated she did not do anything with the Roho cushions. *LPN G was responsible for monitoring and maintaining the Roho cushions. *If she noticed a Roho cushion was flat she would notify LPN G or the nurse on duty. 8. Interview on 1/28/26 at 11:29 a.m. with LPN G revealed: *She verified the Roho cushions were to have protective covers on them. *She should have had resident 5 sit on the Roho cushion, put her fingers under resident 5 and assess if her fingers were able to move without moving her entire hand to ensure theRoho cushion was inflated to an effective level. *She stated the Roho cushions should be checked to determine if they will be effective each time she added or removed air from them. *She stated a pillow, or a pad should not be placed on top of a Roho cushion because it made the Roho cushion less effective. *LPN G stated she was told to add the pillow on top of resident 5's Roho cushion to her care plan because resident 5 requested it. *LPN G stated told resident 5 that the pillow on top of her Roho cushion made it less effective but she did not document that conservation. 9. Interview on 1/28/26 at 12:52 p.m. with director of nursing (DON) B revealed: *LPN G was responsible for checking the residents' Roho cushions when she completed the residents' weekly skin assessments. *She expected the protective covers to be on the Roho cushions. *She stated without the protective covers the plastic	F0658		

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F0658 SS = E	Continued from page 19 of the Roho cushions could cause increased moisture on the skin, which could cause skin breakdown. *She verified a pillow on top of a Roho cushion would make the Roho cushion ineffective. 10. Review of the providers 2022 Roho cushion manufacturer's instructions revealed: *"DO NOT place obstructions between the individual and the cushion. The cushion and the cover MUST be compatible sizes and MUST be used as directed in this manual. Except for the compatible covers listed in 'Product Specifications' in this manual, placement of any items between the individual and the cushion; 1) may reduce or eliminate the benefits of the cushion, increase the risk of skin or other soft tissue, and 2) may cause the individual to become unstable and vulnerable to falling." *"DO NOT use a product that is underinflated or over inflated, because 1) the product benefit will be reduced or eliminated, resulting in and increased risk to skin and other soft tissue, and 2) the individual may be unstable and vulnerable to falling. Carefully follow the instructions for inflations, placement and hand check." 10. Observation and interview on 1/26/26 at 9:32 a.m. with resident 5 in her room revealed: *Resident 5 had a tubi grip (tubular sock that applies pressure to an area to help treat excess fluid or swelling (edema)) on her right lower leg that was rolled on the top and bottom of the tubi grip. *Resident 5 had swelling that overlapped below and above the edges of the tubi grip. *Resident 5 stated she wore the tubi grip at night for the swelling in her legs. 11. Observation and interview on 1/26/26 at 10:28 a.m. with CMA H and LPN G in resident 5's room revealed: *CMA H and LPN G removed the tubi grips from resident 5's legs. *They wrapped the Circaids around resident 5's legs and secured it with the Circaids' Velcro straps. *CMA H and LPN G wrapped the Circaids around resident 5's feet and secured them with the Circaids' Velcro straps.	F0658		

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F0658 SS = E	Continued from page 20 *The heel portion of the Circaids was wrapped under resident 5's arch instead of her heel and did meet or overlap the leg Circaids to provide continuous compression to decrease the edema. *LPN G did not use a measuring tool to measure the amount of pressure the Circaids were applying to resident 5's legs after they were applied. *CMA H stated she assisted LPN G to put on resident 5's Circaids but the nurses were responsible for putting on and removing the Circaids. *CMA H stated she did not know when resident 5 wore tubi grips because they were applied and removed by the nurses. 12. Further review of resident 5's EMR revealed: *Her diagnoses included diabetes (a condition involving disruptions in how the body regulates blood sugar), heart failure (a condition where the heart cannot pump enough blood for the body's needs), peripheral vascular disease (a circulation disorder that involves the narrowing or blocking of blood vessels), and lymphedema. *There was a 1/21/26 physician's order that stated "Foot Circaids". *Resident 5's medication administration record (MAR) stated, "Circaids to feet every shift for diabetic foot ulcer". *There was no physician's order for the use of Tubi grips. 13. Interview on 1/28/26 at 9:40 a.m. with physical therapist (PT) U revealed: *She had received additional training related to resident wounds and Circaids use. *Cicaids were typically used for swelling or lymphedema. *PT U did not know who ordered resident 5's Circaids use originally, but stated resident 5 wore the Circaids since November 2025 when she began working at the facility. *PT U stated Circiads typically were to be on while the resident was up and could be removed at night.	F0658		

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F0658 SS = E	Continued from page 21 *She stated there should be a sleeve applied to the resident's leg before the Circaid, and then the Circaid on top of that. If an ankle or foot Circaid is used with a leg Circaid the Circaids should be close together or overlap. *Once a Circaid was put on, a measuring tool should be used to determine the amount of pressure being applied to the resident's extremity. *The pressure of the Circaid should have been ordered by a physician or physical therapist. *The pressure should be measured each time the Circaid was put on the resident. *She stated that if there was not enough pressure applied to the resident's extremity, the resident's swelling would not be treated, and the resident would have increased edema. If the Circaid was too tight it could cause circulation issues. *She thought a physician's order for Circaids should include when the Circaids were to be on and off the resident, and the pressure the Circaids were to apply. 14. Interview and review of resident 5's EMR on 1/28/26 at 11:29 a.m. with LPN G revealed: *LPN G acknowledged resident 5 had tubi grips on her legs on 1/26/26 at 9:32 a.m. *She stated she did not know where the tubi grip had come from. She had found the box for the tubi grips in resident 5's room that same day (1/26/26) and removed it because resident 5 did not have a physician's order to wear tubi grips. *She thought physical therapy in a neighboring town ordered the Circaids for resident 5 "quite a while ago" but resident 5 refused to wear them. *LPN G stated the nurses were responsible for applying and removing resident 5's Circaides. *When resident 5's feet began to swell more her primary care provider ordered for her Circaids to be worn on her feet. *LPN G stated resident 5 was to wear the Circaids at all times, and they were only to be removed for providing her personal care.	F0658		

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F0658 SS = E	Continued from page 22 *LPN G stated she received some training on the Circaids when they were first ordered. *She was not aware that there was a measuring device that was to be used to determine the amount of pressure the Circaids applied to the area they covered. *LPN G verified the Circaids were only ordered for resident 5's feet, not her legs, and the staff were applying the Circaids to her feet and legs. *She verified the 1/21/26 physician's order for the Circaids was for every shift, but it did not indicate what was supposed to be done every shift. *LPN G acknowledged that the 1/21/26 physician's order did not prompt the nurses to remove the Circaids and assess resident 5's skin for areas of pressure or skin breakdown. 15. Interview on 1/28/26 at 12:52 p.m. with DON B revealed she: *Expected the staff to review the directions for the Cicaids before putting them on a resident. *Was not aware there was a measuring device for the Circaids to determine the amount of pressure the Circaids applied and that pressure would have been part of the order for use. *Reviewed the physician's order in resident 5's EMR and agreed the physician's order included the Circaids on resident 5's feet but did not indicate what the pressures of the Circaids were supposed to be. 16. Review of the provider's undated Circaid manufacturer's instructions manual revealed: *"This compression system is designed to provide upper leg compression to patients with venous and lymphatic disorders." *"Using the Built-In-Pressure System (BPS) Step 1: Locate the BPS card in your packaging. Step 2: Identify the appropriate side of the BPS card based on your ankle circumference. Step 3: Identify your prescribed pressure scale using the color-coded system. Step 4: Starting with the bottom band, line up the	F0658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = E	Continued from page 23 arrow on the BPS card with one of the BPS lines on the bottom band of the component. Step 5: Note where the second BPS line lines up with the card's compression angles. Step 6: If the BPS lines on the component either falls short or goes beyond the correct compression range, readjust the band as necessary so that the second BPS line on the component is aligned with the prescribed compression range." *"Wearing recommendations -Always ensure that the correct pressure range is being applied. Slightly loosen the bands of the component for night-time wear." *"Application instructions Step 1: Slide the circaid undersleeve onto the leg so that it covers the entire leg up to the groin. 17. Observation and interview on 1/26/26 at 8:42 a.m. with resident 33 in his room revealed: *There were two undated disposable urinals on his bedside table. *One of those urinals had a brown ring near the opening on the top if it where resident 33 would urinate into. *Resident 33 stated he was recently given an antibiotic and told he had a UTI. *He stated he was not ill and did not know why he was started on an antibiotic for a UTI because he did not given a urine sample by urinating into a specimen cup. *He was concerned that the staff took the urine sample from the urinals on his bedside table. *Resident 33 pointed at the urinals and stated those urinals were dirty. 18. Review of resident 33's EMR revealed: *He was admitted on 9/3/25. *His 12/3/25 BIMS assessment score was 15, which indicated his cognition was intact.	F0658		

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F0658 SS = E	Continued from page 24 *A 1/21/26 progress note written by LPN G stated, "Resident seen on rounds by Dr [redacted name] for recert [recertification]. Noted crack to right foot beneath toes healed. Resident complaints of right back pain specific to kidney region, new orders for Tylenol 10000 [1,000] mg [milligrams] tid [three times] daily scheduled x [times] 5 days. Cyclobenzaprine [a medication used to relax muscles] 10 mg tid prn [as needed], UA [urinalysis] with micro [microbiology] dx [diagnosis] N". *The urine sample was documented as having been collected by registered nurse (RN) E on 1/22/26 at 4:30 a.m. *There was a 1/24/26 physician's order for Nitrofurantoin (an antibiotic) 100 mg capsule Give 1 cap by mouth every 12 hours for five days for a UTI. 19. Interview on 1/27/26 at 12:05 p.m. with administrator A revealed: *The provider did not have a policy for UA collection. *The staff used the Potter/Perry Fundamentals of nursing 10th edition as their professional standards reference. 20. Interview on 1/27/26 at 6:33 p.m. with RN E revealed: *She collected the urine sample from resident 33 on 1/22/26. *RN E stated resident 33 did not urinate that night until between 3:00 a.m. and 4:00 a.m. *When she saw that resident 33 had urinated in his urinal she got a urine specimen cup, poured the urine from his urinal into the specimen cup, labeled the urine cup with resident 33's name, put the urine specimen cup in a bag, and placed the bag into the refrigerator. *RN E verified she did not replace resident 33's urinal with a clean urinal before he urinated in it. *She stated she used the urinal that was already beside his bed when she came to work. *She did not know when that urinal was given to resident 33. 21. Interview on 1/28/26 at 10:28 a.m. with CNA K	F0658		

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F0658 SS = E	Continued from page 25 revealed: *The urinals in residents' rooms were replaced by the hospitality aids but there was no established schedule for when the urinals were to be replaced. *There was no documentation when the urinals were replaced, and the urinals were not dated when they were replaced. 22. Interview on 1/28/26 at 11:18 a.m. with LPN G revealed a resident's urine sample that was to be tested for a potential infection should not be collected from a previously used urinal due to the risk of it being contaminated. 23. Interview on 1/28/26 at 12:52 p.m. with DON B revealed: *She expected the nurses to follow the Potter/Perry nursing standards of practice when they collected a urine sample. *She stated the resident's genitals were to be cleaned, the resident should urinate into the toilet or urinal and then the sample should be collected in a urine specimen cup. *The urinals were to be replaced every month and as needed if they became soiled. *DON B verified RN E did not follow the standards of practice when she collected the urine sample from resident 33, which could have resulted in a contaminated urine sample that resident 33 was being treated with antibiotics for. 24. Review of the provider's professional standards reference Potter/Perry Fundamentals of nursing 10th edition revealed: *"COLLECTING MIDSTREAM (CLEAN-VOIDED) URINE SPECI 2. Collect clean-voided urine specimen. a. Perform hand hygiene and apply clean gloves. Give patient cleaning towelette or towel, washcloth, and soap to clean perineum [the area between the anus and genitals] to help with cleaning perineum… -Cleaning prevents contamination of specimen from skin and surface bacteria after urine passes from the urethra…	F0658 EN…		

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F0658 SS = E	Continued from page 26 e. Open specimen container, maintaining sterility of inside specimen container, and place cap with sterile inside up. Do not touch inside the cap or container. -Contaminated specimen is most frequent reason for inaccurate reporting of urine C&S [culture and sensitivity] f. Use aseptic technique to help patient or allow patient to independently clean perineum and collect specimen… (1) Male: (a) Hold penis with one hand using a circular motion and antiseptic towelette, clean meatus, moving from center to outside 3 times with 3 different towelettes… -Reduces number of microorganisms at urethral meatus and moves from areas least to most contamination… (c) After patient initiates urine stream into toilet, urinal, or bedpan, have him pass urine specimen container into stream and collect 90 to 120 ml [milliliters] of urine. -Initial urine flushes out microorganisms that normally accumulate at urinary meatus and prevents transfer into specimen."	F0658		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	1.The dishmachine temperature log with missing temperatures cannot be altered. 2.The Dietary Manager or designee will educate all dietary staff on the Recording Dishmachine Temperature Policy by 2/13/26. Any staff not in attendance will receive the education prior to their next scheduled shift. 3.The Dietary Manager or designee will audit the dishmachine temperature log for 5 random days weekly x 4 and monthly x 3 to ensure the wash/rinse temperatures are recorded. Results of the audits will be presented by the Dietary Manager or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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F0812 SS = E	Continued from page 27 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to monitor and document the temperatures for one of one commercial dishwashing machine according to the provider's policy to ensure it reached the minimum rinse cycle temperature of 180 degrees for sanitization of dishes and equipment used to prepare and serve residents' meals after every meal service. Findings include: 1.Observation and interview on 1/25/26 at 11:41 a.m. in the main kitchen with dietary aide R revealed: *A clipboard hanging on the wall at the end of the dish machine tray line with dishwasher temperatures on it. *The January 2026 dishwashing machine temperature log did not have temperatures documented for: -Breakfast on 1/12/26, 1/14/26, 1/21/26, and 1/24/26. -Lunch on 1/12/26, 1/14/26, 1/21/26, and 1/24/26. -Dinner on 1/10/26, 1/12/26, 1/13/26, 1/14/26, 1/15/26, and 1/20/26. *The manufacturer's sign attached to the dish machine stated: -"NSF Machine Operation Requirements as Manufactured by CMA Dish machines. Wash Temperature-Minimum 155 degrees F cycle. Wash cycle Time 49 seconds. Rinse temperature minimum 180 degrees F cycle. Rinse Cycle time 12 seconds." *Dietary aide R stated the temperatures should have been recorded after each meal. *Dietary aide R confirmed the dish machine used a high temperature rinse and should be a minimum of 180	F0812		

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F0812 SS = E	Continued from page 28 degrees. *Further review of the January 2026 dish machine temperature log revealed there were nine documented temperatures below 180 degrees. *Dietary aide R agreed the rinse temperature log was not always documented at or above the 180 degree minimum for a high temperature rinse dish machine. 2. Interview and record review on 1/25/26 at 12:42 p.m. with maintenance director N revealed: *She knew the temperature had to be at least 180 degrees. *She did not receive any notices from the kitchen staff that it was not meeting rinse temperature. *She would notify the vendor if there were issues with the dish machine. *Her expectation was the dietary manager would notify her if the dish machine was not getting to 180 degrees during the rinse cycle. *She stated the dish machine has a heat booster that should notify staff if it was not up to temperature and sometimes the staff needed to run an extra rinse cycle to help reach the correct temperature. *She agreed there were 14 documented temperatures in January that did not reach 180 degrees. 3. Review of the dish machine temperature logs from October 2025 through December 20205 revealed: *The October logs were missing 25 rinse temperature logs out of 93 opportunities. *The November logs were missing 14 rinse temperature logs out of 90 opportunities, and three temperatures were documented below 180 degrees. *The December logs were missing 8 rinse temperature logs out of 93 opportunities, and nine temperatures were documented below 180 degrees. 4. Interview on 1/27/26 at 9:13 a.m. with dietary aide M regarding the dish machine revealed:	F0812		

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F0812 SS = E	Continued from page 29 *She knew some of the documentation for the rinse temperature logs were not indicating 180 degrees. *She was not sure who had done that documentation. *She stated if she had issues with the dishwasher she would notify her boss, who would then notify maintenance. 5. Interview on 1/27/2026 2:40 p.m. with dietary manager L regarding dish machine temperatures revealed: *She would notify maintenance if there was an issue with the dish machine. *She expected staff to document the wash and rinse temperatures for the dish machine after all meals. *She agreed that did not happen for some meals. 6. Interview on 1/28/26 at 11:51 a.m. with administrator A regarding dish machine temperatures revealed: *Her expectation was that staff would document dish machine temperatures. *She thought dietary staff were not waiting for the rinse cycle to document the accurate temperature. *She agreed the documentation was not supporting the rinse cycle meeting the 180 degree minimum temperature. 7. Review of the manufacturer's instructions for the dish machine revealed: *"The wash temperature must be 155 F (Fahrenheit) minimum. The rinse temperature must be 180 F." *"If necessary, adjust the temperature by removing the panel in front of the respective heater and turning the adjustment stem clockwise to increase." 8. Review of the provider's 6/6/19 revised Recording of Dish Machine Temperature policy revealed: *"3. Record temperatures every shift on Dish Machine Temperature Log (FORM 408) or other designated form or on Food Temperature and Sanitation Record (FORM 401B)."	F0812		

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F0812 SS = E	Continued from page 30 *"High Temperature Dish Machines Rinse temperature >180 (degrees) F (Fahrenheit)." *"Or follow manufacturer's directions, if different." *"4. Any inaccurate temperatures must be brought to the attention of the Director of Food and Nutrition Services or other clinically qualified nutrition professional immediately."	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	1.Immediate education was provided to CMA (H), LPN (G) and CNA (S) on hand hygiene and glove use and hand hygiene and use of PPE on 1/29/26 by RN Supervisor. 2.The Director of Nursing or designee will educate all staff on hand hygiene and glove use and don and doffing of PPE by 2/19/26. Any staff not in attendance will receive the education prior to their next scheduled shift. 3.The Director of Nursing or designee will audit hand hygiene and glove use and donning and doffing of PPE weekly x 4 and monthly x 3 to ensure staff are following standard infection control practices. Results of the audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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F0880 SS = E	Continued from page 31 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff followed standard infection control practices regarding: *Hand hygiene (handwashing or hand sanitizer use) and gloves used by one of one certified medication aide (CMA) (H), and one of one licensed practical nurse (LPN) (G) while providing personal cares for resident 5. *Hand hygiene and use of personal protective equipment (PPE) (such as a gown, gloves, and mask) by one of one certified nursing assistant (CNA) (S) observed while delivering meal trays to four of four sampled residents (10, 14, 20, and 22) with COVID-19 (a contagious	F0880		

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F0880 SS = E	Continued from page 32 disease that can spread quickly) and on enhanced droplet precautions (which need and a N95 mask (a mask that filters 95 percent of airborne particles), gown, gloves, and eye protection to be worn when entering those rooms) according to the provider's policy. Findings include: 1. Observation on 1/25/26 at 11:58 a.m. of CNA S passing lunch trays to residents in their rooms revealed: *On the door of resident 10's room was a sign for enhanced droplet precautions (EDP). *The alcohol-based hand sanitizer (ABHS) dispenser outside resident 10's room did not have hand sanitizer in it. *Without performing hand hygiene, CNA S put on a gown, removed her surgical mask and placed it in the pocket of her pants, put on a N95 mask, put on a pair of gloves, tied the gown around her back, and took resident 10's food into his room. -CNA S did not put on eye protection before entering resident 10's room. *CNA S exited resident 10's room with an uncovered garbage can, set the garbage can down outside the resident's door, and with the same gown, gloves, and N95 mask on. *CNA S removed her gown, gloves and N95 mask in the hallway and discarded them in the uncovered garbage can. *She took her used surgical mask out of the pocket of her pants and put it on. *She attempted to use the ABHS from the hallway dispenser outside of resident 10's room, but the dispenser did not dispense hand sanitizer. *CNA S then pushed the cart with other residents' meal trays on it down the hallway. *Outside of resident 20's room, without performing hand hygiene CNA S put on a gown, put the surgical mask she was wearing in the pocket of her pants, then put on an N95 mask, a pair of gloves, and a face shield. *She entered resident 20's room with the resident's	F0880		

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F0880 SS = E	Continued from page 33 meal tray. *On resident 20's door was a sign that indicated she was on EDP. *CNA S exited resident 20's room with an uncovered garbage can with the same gown, gloves, and N95 mask on. *CNA S removed her gown, gloves and N95 mask in the hallway and discarded them in the uncovered garbage can. *She then put on the used surgical mask from her pants pocket and sanitized her hands with ABHS. *CNA S went to resident 14's room, which had a sign on the door that stated he was on EDP. *Outside of resident 14's room, without performing hand hygiene, CNA S put on a gown, put the used surgical mask she was wearing in the pocket of her pants, and put on an N95 mask, a pair of gloves, and a face shield. *She entered resident 14's room with his meal tray. *CNA S exited resident 14's room with an uncovered garbage can and with the same gown, gloves, and N95 mask on. *CNA S removed her gown, gloves and N95 mask in the hallway and discarded them in the uncovered garbage can in the hallway. *She put on the used surgical mask from her pocket and sanitized her hands with ABHS. *CNA S pushed the cart with the residents' meals on it to resident 22's room, which had a sign on the door that stated he was on EDP. *Outside of resident 22's room, without performing hand hygiene, CNA S put on a N95 mask over her surgical mask, put on a gown, a pair of gloves, and a face shield. *She entered resident 22's room with his meal tray. *CNA S exited resident 22's room with an uncovered garbage can and with the same gown, gloves, and N95 mask on. *CNA S removed her gown, gloves and N95 mask in the	F0880		

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F0880 SS = E	Continued from page 34 hallway, discarded them in the uncovered garbage can in the hallway, and sanitized her hands with ABHS. 2. Interview on 1/25/26 at 12:08 p.m. with CNA S revealed residents 10, 14, 20, and 22 were on EDP because they had COVID (COVID-19). 3. Observation on 1/26/26 at 10:28 a.m. of CMA H and LPN G changing resident 5's wound dressings revealed: *On the outside of resident 5's door was a sign that stated she was on enhanced barrier precautions (EBP) (glove and gown use when providing contact care). *CMA H and LPN G each put on a gown and a pair of gloves without performing hand hygiene. *LPN G washed the wound on resident 5's right foot, removed her gloves, discarded them in the garbage can, and without performing hand hygiene, put on a clean pair of gloves. *LPN G placed a clean dressing over resident 5's foot wound, put a compression wrap on resident 5's leg, removed her gloves and discarded them in the garbage can, did not perform hand hygiene, and put on a clean pair of gloves. *CMA H assisted LPN G with putting the compression wrap on the resident, then removed her gloves, discarded them in the garbage can, did not perform hand hygiene, and put on a clean pair of gloves. *CMA H took the garbage bag out of the garbage can and set it on the floor, put a new garbage bag in the garbage can, removed her gloves discarded them in the garbage can, did not perform hand hygiene, and put on a clean pair of gloves. *CMA H and LPN G assisted resident 5 to a standing position, removed her incontinence brief, and washed resident 5's buttocks. *LPN G removed her pair of gloves, discarded them in the garbage can, did not perform hand hygiene, put on a clean pair of gloves, and measured resident 5's wounds on her buttocks and thighs. *LPN G took the garbage out of the garbage can, put a new garbage bag in the garbage can, removed her gloves, discarded them in the garbage can, and performed hand hygiene. *CMA H assisted resident 5 into a wheelchair, CMA H	F0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 35 removed her gloves, discarded them in the garbage, did not perform hand hygiene, put on a clean pair of gloves, and handed resident 5 a glass of water. *CMA H then cleansed resident 5's finger with an alcohol swab, poked resident 5's finger with a lancet and collected a drop of resident 5's blood to check her blood sugar. *CMA H removed her gloves, discarded them in the garbage, and performed hand hygiene before she left resident 5's room. 4. Interview on 1/28/26 at 10:28 a.m. with CNA K revealed: *Hand hygiene should be completed before and after providing any resident's care needs, before putting on gloves, and after removing gloves. *A resident on EDP required staff to put on a gown, a pair of gloves, an N95 mask, and eye protection before entering the resident's room. *When she exited a resident's room who was on enhanced droplet precautions, she sometimes took her gown and gloves off in the room and sometimes she took them off in the hallway. It depended on where the garbage can was located. *She acknowledged that the garbage cans in the hallway where the gowns, gloves, and masks were disposed of were not covered, which could expose others in the hallway to COVID-19. 5. Interview on 1/28/26 at 11:08 a.m. with LPN G revealed: *Hand hygiene should be performed before and after providing any resident's care needs, before entering a resident's room, after leaving a resident's room, before putting on gloves and after removing gloves. *She verified she did not wash her hands during resident 5's dressing change. *When a resident was on EDP staff were to put on PPE before entering the resident's room and remove the gown and gloves before they exited that resident's room. *The used gown and gloves should be put in the garbage can inside the resident's room, the N95 mask was to be placed in a garbage can outside of the resident's room, and a new surgical mask was to be put on.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST , REDFIELD, South Dakota, 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 36 6. Interview on 1/28/26 at 12:52 p.m. with director of nursing (DON) B revealed: *Hand hygiene was to be completed before a staff member entered a resident's room, after leaving a resident's room, before putting on gloves and after removing a pair of gloves, and before and after providing any resident's care needs. *She expected staff to put PPE on before entering the room of a resident who was on EDP, remove and dispose of their gown and gloves in the resident's room, exit the room, remove their N95 mask, wash their hands, and put on a clean surgical mask. 7. Review of the provider's October 2019 Hand Hygiene policy revealed: *"This facility considers hand hygiene the primary means to prevent the spread of infections." *"In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents b. When entering and leaving a Resident care area/room c. Before donning [putting on] and after removing gloves; d. Before performing any non-surgical invasive procedures; e. Before preparing or handling medications; f. Before handling clean or soiled dressings, gauze pads, etc.; g. Before moving from a contaminated body site to a clean body site during resident care; h. After contact with a resident's intact skin; i. After handling dressings, contaminated equipment, etc.; j. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 37 k. After contact with body fluids, mucous membranes and non-intact skin or dressing." *"Hand hygiene is always the final step after removing and disposing of personal protective equipment." Review of the provider's 1/26/25 Transmission Based Precautions policy revealed: *"For diseases that have multiple routes of transmission, more than one transmission based precaution category may be required (e.g., Droplet and Contact for COVID-19 etc.)" *"Precautions signage will be placed on the door or door jamb. Don (put on) appropriate PPE BEFORE entry to room or cubicle." *"Soiled laundry and trash containers will be placed inside the room. PPE will be placed in these containers after doffing (removing) PPE and/or soiled linen items are used. Hand hygiene will be performed." *"CONTACT PRECAUTIONS… -Hand hygiene should be completed prior to donning and after removal of gloves. -Gloves should be worn when entering the room and while providing care for the resident. -Gloves should be changed when contaminated (e.g., handling fecal material and wound drainage). -Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately." -"A gown should be donned prior to entering the room or resident's cubicle." -"The gown should be removed before leaving the resident's room." *"DROPLET PRECAUTIONS… -Hand hygiene should be completed prior to donning and after removal of gloves. -Gloves should be worn when entering the room and while providing care for the resident. -Gloves should be changed when contaminated (e.g., handling fecal material and wound drainage).	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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F0880 SS = E	Continued from page 38 -Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately." *"Enhanced Droplet Precautions (Use of Contact and Droplet Precautions together) 1. Under certain circumstances, such as a novel respiratory infection (e.g., COVID-19) the CDC [Center for Disease Control] recommends the use of both Contact and Droplet Precautions together. All residents with contact and droplet precautions will be identified with an Enhanced Droplet Precautions/Contact and Droplet Precautions sign on the resident's door or door jamb. 2. Follow above requirements for Standard, Contact Precautions and Droplet Precautions, including use of full PPE: a. N95 respirator must be used along with gown, gloves, and eye protection."	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - MAIN BUILDING 0... B. WING	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST , REDFIELD, South Dakota, 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A recertification survey was conducted on 1//27/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Redfield Building 01 was found in compliance.	K0000		
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K0321	1.The two separate hazardous areas: AACU storage room door was adjusted to close and latch on 2/11/26 and kitchen pantry storage room was closed immediately on 1/27/26. 2.The Maintenance Director was educated regarding hazardous areas and having a self-closing or automatic closing door on 1/27/26. 3. The Maintenance Director or designee will audit random hazardous areas of the facility weekly x 4 and monthly x 3 to ensure the doors close and latch. Results of the audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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 reverse for further 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
Diane Forgey	Administrator	2/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST , REDFIELD, South Dakota, 57469

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K0321 SS = D	Continued from page 1 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain two separate hazardous areas (AACU storage room and kitchen pantry storage room) as required. Findings include: 1. Observation on 1/27/26 at 1:56 p.m. revealed storage room in the AACU wing (converted resident room 35) was over 100 square feet and contained combustible items. Testing of hat corridor door revealed it did not close and latch on three of three attempts with the operation of the automatic door closer. 2. Observation on 1/27/26 at 2:33 p.m. revealed the kitchen pantry storage room was over 100 square feet and contained combustible items. The pantry door was equipped with a door closer, however the door was chocked open with a sheet pan lid on top of the can storage rack that prevented it from closing. That pantry was not separated from the egress path with a self-closing door. Interview with the maintenance director at the times of the observations confirmed those findings.	K0321		
K0712 SS = E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K0712	1.The fire drills that were not completed in quarter 4 are unable to be corrected. 2. The Maintenance Director was educated on the facility fire drill procedures including the number of required fire drills on 1/27/26. The facility will conduct one fire drill per shift per month. 3. The Maintenance Director or designee will audit fire drills weekly x 4 and monthly x 3 to ensure the required number of drills are completed. Results of the audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0712 SS = E	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review at 1/27/26 at 3:45 p.m. revealed there was no documentation of fire drills being conducted for second or third shift fire drills for quarter four (October, November, December) 2025. Interview with the maintenance director at the time of the record review confirmed those findings. She stated she was aware the facility had not conducted the minimum number of fire drills required for each shift of quarter four for 2025. The deficiency had the potential to affect 100% of the occupants of the building.	K0712		
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by:	K0761	1.The two cross-corridor doors that failed to maintain the fire-resistive design were adjusted to latch properly on 2/11/26. 2. The Maintenance Director was educated on maintaining the fire-resistive design of ninety-minute doors 1/27/26. 3. The Maintenance Director or designee will audit the integrity of the latch of fire resistive doors weekly x 4 and monthly x 3 to ensure the fire-resistive doors latch properly. Results of the audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - MAIN BUILDING 0... B. WING	01/27/2026

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K0761 SS = D Bldg. 01	Continued from page 3 Based on observation, testing, and interview, the provider failed to maintain the fire-resistive design of one randomly of ninety-minute fire-rated doors (fire doors outside of therapy). Finding include: 1. Observation and testing on 1/27/26 beginning at 2:19 p.m. revealed the cross-corridor doors just outside the therapy room were ninety-minute fire-rated doors in the two-hour fire separation wall between building one and building two. Testing of those doors revealed the north leaf would close but the top latching mechanism would latch into the door frame under the power of its automatic door closer on three of three attempts. Fire-rated doors must close and latch to maintain their fire ratings. 2. Observation and testing on 1/27/26 beginning at 3:01 p.m. revealed the cross-corridor doors north of the nurse station were ninety-minute fire-rated doors in a building two-hour fire separation wall. Testing of those doors revealed the west leaf would strike the east leaf causing it not to close and latch into the door frame under the power of its automatic door closer on three of three attempts. Fire-rated doors must close and latch to maintain their fire ratings. Interview with the maintenance director at the time of the observations confirmed those findings. She stated they recently hired a professional fire door inspection company to inspect and adjust all the fire rated doors in the facility, to ensure they were operating correctly. She also added she was unaware those doors were not operating correctly and was surprised it happened so soon after the professional fire door inspection/testing.	K0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS A recertification survey was conducted on 1//27/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Redfield Building 02 was found in compliance.	K0000		
K0712 SS = E Bldg. 02	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review at 1/27/26 at 3:45 p.m. revealed there was no documentation of fire drills being conducted for second or third shift fire drills for quarter four (October, November, December) 2025. Interview with the maintenance director at the time of the record review confirmed those findings. She stated she was aware the facility had not conducted the minimum number of fire drills required for each shift of quarter four for 2025.	K0712	1.The fire drills that were not completed in quarter 4 are unable to be corrected. 2. The Maintenance Director was educated on the facility fire drill procedures including the number of required fire drills on 1/27/26. The facility will conduct one fire drill per shift per month. 3. The Maintenance Director or designee will audit fire drills weekly x 4 and monthly x 3 to ensure the required number of drills are completed. Results of the audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	**A.** BUILDING **02 - BUILDING 02** B. WING	**01/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST , REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0712 SS = E Bldg. 02	Continued from page 1 The deficiency had the potential to affect 100% of the occupants of the building.	K0712		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10671	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on from 1/25/26 through 1/28/26. Avantara Redfield was found not in compliance with the following requirement: S153.	S 000		
S 153	44:73:02:11 Plumbing A facility's plumbing systems must be designed and installed in accordance with SDCL 36-25-15 and 36-25-15.1 and article 20:54. Plumbing must be sized, installed, and maintained to carry required quantities of water to required locations throughout the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain plumbing in accordance with SDCL 36-25-15 and 36-25-15.1 and article 20:54 in one randomly observed location (west wall across from the nurse station). Findings include: 1. Observation and interview on 1/27/26 beginning at 1:12 p.m. revealed an abandoned two-inch inlet to the sanitary sewer drainage system on the west wall across from the nurses' station. That location appeared to previously have been a location for a drinking fountain. That sewer inlet had been blocked off using a rag . At the time it was observed that rag was discolored and hanging out of the inlet. That rag would not provide a positive connection to ensure sewer gas or sewage back-up could not enter the facility.	S 153	1.The abandoned two-inch inlet to the sanitary sewer drainage system was capped off and closed on 2/12/26. 2.The Maintenance Director was educated on the administrative rule 44:73:02:11 on 1/27/26. 3. The Maintenance Director or designee will audit random areas of the facility weekly x 4 and monthly x 3 to ensure the administrative rule regarding plumbing is being followed. Results of the audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations until substantial compliance has been met.	4. 3/6/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Forgey	Administrator	2/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10671	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 153	Continued From page 1 Interview with the maintenance director at the same time as the observation revealed she believed that location had previously been a drinking fountain and that she was unaware that pipe was in the condition found as the cart used as a hydration station was normally placed in front of the pipe.	S 153		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 1/27/26. Avantara Redfield was found in compliance.	E0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Forgey	Administrator	2/18/26