STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435059	A. BUILDING _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK STREET LAKE NORDEN, SD 57248

(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
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/18/25 through 3/20/25. Avantara Lake Norden was found not in compliance with the following requirement: F657	F 000		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	1. The care plans were updated on March 19, 2025 for Resident 5, 18, 20, 21, and 23 along with the other residents in the Memory Care Unit to accurately reflect the resident's abilities to use call lights effectively with impaired cognition. Audits began on the main floor to ensure the care plan reflects the resident's abilities to use call lights effectively. 2. All residents have a potential to be impacted by the care plan not accurately reflecting the resident's abilities to use call lights effectively with impaired cognition. Education was provided by Health Facilities Surveyors on March 19, 2025 to Memory Care Unit Director, Director of Nursing and Administrator.	April 25, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Grimm	Administrator	04/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	Continued From page 1 by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were updated to accurately reflect the residents' abilities to use call lights effectively for five of five observed sampled residents (5, 18, 20, 21, and 23) with impaired cognition who resided in the memory care unit (MCU). Findings include: 1. Observation and interview on 3/18/25 at 9:35 a.m. and again on 3/19/25 at 1:38 p.m. with resident 5 revealed: *Resident 5 sat on the edge of her bed and her call light was attached to the curtain in the center of the room between the two beds on the opposite side of the room from her bed on her roommate's side of the room on both days. -Both call lights were on the same side of the room away from resident 5. -She was unsure if there was a call light. She looked around and stated, "It wouldn't do me any good if I can't get to it." -She said she would go to the dining room when she needed something. Review of resident 5's electronic medical record (EMR) revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated she was severely cognitively impaired. *Her diagnosis included dementia (a decline in memory, thinking, and reasoning abilities that significantly impacts daily life) and amnesia (a loss of memory, either temporary or permanent, that can involve forgetting past events, personal information, or the inability to form new memories) *Her care plan included interventions that were	F 657	3. Education to the Interdisciplinary Team was provided on March 20, 2025 by Memory Care Unit Director on the need for the care plans to accurately reflect the resident's abilities to use call lights effectively with impaired cognition. 4. Director of Nursing (DNS)or designee conducted 100% audits and monitoring for the need for the care plans to accurately reflect the residents abilities to use call lights effectively with impaired cognition. Audits of all new admisison and significant change of status of current residents will be completed weekly for four weeks. Then monthly audits will continue for two months. Monitoring results will be reported by the DNS or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 657	Continued From page 2	F 657		

initiated:
-On 8/2/24 to "Keep call light within reach when in bedroom or bathroom."
-On 8/15/24 to "[Keep] Call light within reach and provide reminders to use call light to ask for assistance."

2. Observation on 3/18/25 at 8:51 a.m. and again on 3/19/25 at 1:32 p.m. revealed resident 18's call light was clipped on the curtain in the center of the room approximately five feet from the floor inaccessible to the resident from the bed or chair on both days.

Review of resident 18's EMR revealed:
*Her BIMS score was 4, which indicated she was severely cognitively impaired.
*She had a diagnosis of dementia.
*Her care plan included interventions that were initiated:
-On 5/15/24 to "Keep call light within reach."
-On 9/3/24 to "Keep call light and personal items available and in reach."

3. Observation and interview on 3/18/25 at 8:53 a.m. with resident 20 revealed:
*Resident 20 was lying in bed and his call light was clipped to the top left corner of his mattress near his head.
-He was unsure how to get a nurse to come to his room.
-When asked, he did not know where the call light was located.

Review of resident 20's EMR revealed:
*His BIMS score was 9, which indicated he was moderately cognitively impaired.
*His diagnoses included dementia and seizures.
*His care plan interventions included, "Keep call

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F 657	Continued From page 3	F 657		

light within reach," initiated on 9/30/24.
*A 2/22/25 progress note, indicated "Resident found by CNA [certified nursing assistant] after she heard something. He was sitting on [his] buttocks on [the] floor. Stated he was reaching for water...Call light clipped to wall...Did not ring for assistance."
*A physician's order "May have silent alarm to alert staff without alarming him," was dated 2/24/25 and discontinued on 3/18/25.

4. Observation on 3/18/25 at 8:47 a.m. and again on 3/19/25 at 1:30 p.m. with resident 21 revealed:
*Resident 21's call light was clipped to the curtain in the center of the room between the two beds, which was inaccessible to the resident from his bed on both days.

Review of resident 21's EMR revealed:
*His BIMS score was 3, which indicated he was severely cognitively impaired.
*He had a diagnosis of dementia.
*His care plan interventions included, "Keep call lights within reach when in bedroom or bathroom," initiated on 4/26/21.

5. Observation and interview on 3/18/25 at 8:57 a.m. and again on 3/19/25 at 1:33 p.m. with resident 23 revealed:
*Resident 23's call lights were clipped to themselves on the wall in the center of the room on both days and were inaccessible to the resident.
-She stated she did not know if there was a button to push if she needed help and she would "just go out in the hallway and call for help".

Review of resident 23's EMR revealed:
*Her BIMS score was 4, which indicated she was

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F 657	Continued From page 4	F 657		

severely cognitively impaired.
*She had a diagnosis of dementia.
*Her care plan interventions included, "Keep call light within reach when in room or bathroom, encourage to use and to wait for assistance. Doesn't always understand/remember to use. Keep call lights within reach when in bedroom or bathroom" initiated on 9/3/21.

6. Interview on 3/19/25 at 10:50 a.m. CNA F revealed:
*Some residents in the MCU knew how to use their call lights but many did not.
*One resident had a "silent alarm" that alerted staff when she got out of bed.
*Resident 20's silent alarm was discontinued "yesterday" (3/18/25).

7. Interview on 3/19/25 at 2:51 p.m. with Alzheimer's care director D regarding resident call lights on the memory care unit revealed:
*Residents in the MCU "never" used their call lights.
*They tried to keep the call lights "close by" in case the staff needed to use them.
-Staff also used radios to call for help when needed.
*She declined to look at the call lights in specific resident rooms and stated, "I know where they are."
-She stated some call lights were clipped on the curtain and others were clipped to themselves at the wall.
*Some call lights were intentionally left out of reach of the residents for safety reasons.
*She was not responsible for the care plan areas that had indicated to leave resident call lights within reach of the residents.
-She indicated the Minimum Data Set (MDS)

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F 657	Continued From page 5	F 657		

coordinator would have completed that specific part of the residents' care plans.
*She expected the care plan would indicate that the call lights were within reach "for staff."
*She expected the care plans to represent the residents' abilities.
*Resident 5 might have moved the call light herself when she made her bed.
*Resident 18 was unable to use a call light to request assistance. Staff were to anticipate her needs.
*She was unsure if resident 20 knew what the call light was.
*Resident 23 may have clipped her call light to the wall because she removed pictures from the walls and moved items around in her room.

8. Interview on 3/19/25 at 3:17 p.m. with MDS coordinator E revealed:
*She completed the resident care plan areas related to activities of daily living, mobility, and toileting.
*Information was updated in the resident's care plan with every assessment.
*She made sure to add that call lights were within reach in the bathroom or within their room to every care plan.
-She had been told it needed to be on "every care plan regardless of the resident's ability."
*She felt the residents' care plans should be a reflection of the resident's needs and be person-centered.
*She had not worked in a facility with a memory care unit before working at this facility.
*She was unaware that the call lights in the memory care unit would sometimes be intentionally placed out of reach of the resident for safety reasons.
*If call lights were determined to be a safety risk

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F 657	Continued From page 6 to the resident that should have been indicated on the care plan. 9. Interview on 3/19/25 at 3:40 p.m. with administrator A, director of nursing B, and regional nurse consultant G revealed: *They expected the care plans would accurately reflect the residents' individualized needs. *Some residents in the MCU might not be able to use their call lights. *It was possible that the call light could present a safety hazard to a resident in the memory care unit. Review of the provider's revised 9/30/24 Care Plans 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. In doing so the following considerations are made: Each resident is an individual..." *"Care Plans should be updated between care conferences to reflect the current care needs of the individual resident as changes occur."	F 657		

South Dakota Department of Health

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	10639	A. BUILDING: _____ B. WING _____	03/20/2025

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AVANTARA LAKE NORDEN	803 PARK ST POST OFFICE BOX 139 LAKE NORDEN, SD 57248

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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 from 3/18/25 through 3/20/25. Avantara Lake Norden was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm
TITLE: Administrator
(X6) DATE: 04/03/2025