STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 11/14/24. The area surveyed was neglect and quality of care. Avantara Norton was found not in compliance with the following requirement: F600.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review, the provider failed to protect one of one sampled resident (1) from neglect by certified nursing assistant (CNA) (C) who did not provide timely care, which potentially resulted in the resident being incontinent for an unknown length of time and may have contributed to the resident's development of two skin sores. Findings include:	F 600	1. Resident 1 had a skin assessment completed following the reported allegation of neglect. Certified nursing assistant (CNA) C was suspended pending results of the investigation of the allegation of neglect. CNA C received education on the Abuse and Neglect policy to include ensuring residents are check and changed at least every 2 hours prior to being reinstated on October 30, 2024. 2. All residents are at risk for being incontinent for an unknown length of time resulting in the potential for development of skin sores due to not being provided timely care.Director of Nursing (DON) or designee will educate all staff, including CNA C, on the Abuse and Neglect policy to ensure residents receive timely care. In addition, the DON or designee will educate all nursing staff on the Skin and Pressure Injury Prevention Program to ensure residents are repositioned at least every 2 hours to include checking and/or changing of resident's brief. Education will occur no later than December 11, 2024, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	12/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	LNHA	11/26/24

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 600	Continued From page 1 1. Review of the provider's SD DOH FRI submitted on 10/26/24 at 4:23 p.m. revealed: *CNA C worked in the wing where resident 1 resided during the night shift of 10/25/24. *CNA C had asked CNA D to assist her with her assigned residents, and she had assumed resident 1's care needs had been provided by CNA D. *CNA C did not verify resident 1's care had been provided. *CNA D stated she did help on CNA C's wing, but did not help with resident 1. *Camera footage for the time period was reviewed and revealed that resident 1 was checked on at 10:00 p.m. by CNA F and was not checked on again until approximately 4:30 a.m. on 10/26/24 by licensed practical nurse (LPN) G when he administered resident 1's morning medications. -LPN G reported resident 1 was in bed when he gave her her morning medications. *CNA F reported at 10:00 p.m. resident 1 was still sitting in her chair and did not want to go to bed. *Resident 1 was not checked on again until approximately 8:30 a.m. and was found to have been incontinent with stool on her bed sheets. *Resident 1's Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated she had severe cognitive impairment and was therefore unable to be interviewed about the above incident. *A skin assessment was performed after the above incident that indicated the discovery of a stage 2 pressure ulcer (an open sore or blister) on resident 1's left buttock, that measured 1.7 centimeters (cm) by 0.4 cm and a stage 2 pressure ulcer to her right buttock, that measured 1.5 cm by 0.9 cm. *The allegation of neglect by CNA C was	F 600	3. The DON or designee will interview 5 residents every week to ensure they remain free from abuse and/or neglect. The DON or designee will audit 5 dependent residents to ensure care is provided timely with resident being checked and/or changed at least every 2 hours. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 600	Continued From page 2 substantiated (confirmed) by the provider's investigation of the incident. *CNA C was given disciplinary action, education to check on residents every two hours and change incontinence products if needed, and of the facility's abuse and neglect policy. 2. Interview on 11/14/24 at 11:00 a.m. with administrator A and director of nursing (DON) B revealed: *The camera footage regarding the above incident was reviewed by DON B and he verified resident 1 was left unattended from approximately 10 p.m. to 4:30 a.m., and then again from 4:30 a.m. to approximately 8:00 a.m. *DON B verified resident 1 could not have been checked for incontinence or changed when necessary. *Referring to when a CNA would ask for help from another CNA, DON B's expectation was that each CNA was responsible for the residents in their assigned unit. -CNA C was responsible for ensuring resident 1's care needs were provided. *It was DON B's expectation that residents would be checked on at least every two hours. 3. Interview on 11/14/24 at 12:10 p.m. with CNA E revealed: *She had been a CNA for several years. *She felt it was a general expectation that all residents were to be checked on and changed as necessary at least every two hours. *Referring to when one CNA would ask for assistance from another CNA, she stated she would check on her resident as soon as she was able to ensure residents had received proper care. *When a CNA would help with residents in	F 600		

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F 600	Continued From page 3	F 600		

another wing, it was still the responsibility of that CNA to ensure cares were completed for their assigned residents.

4. Phone interview on 11/14/24 at 1:06 p.m. with resident 1's granddaughter revealed:
*She did not have any concerns about the care her grandmother was receiving.
*She had been notified of the above incident and of resident 1's two skin sores.

5. Interview on 11/14/24 at 1:15 p.m. with administrator A revealed:
*They did not have a specific written check and change every two hours policy, but it was their expectation that residents would be checked on and changed as necessary at least every two hours.
*She stated this was considered a professional standard.
*After the incident, CNA C had been educated on checking residents and changing as necessary every two hours.
*There had been no facility-wide education provided to staff to "check and change" residents every two hours since the incident.

6. Review of the provider's toileting and incontinence policy revealed: "As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, bowel routines, or other interventions to try to manage incontinence."

7. Review of the provider's CNA job description revealed:
*Essential Functions number 4. "Attends to individual needs of all Guests [residents] in

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F 600	Continued From page 4 regards to incontinent care, transferring, ambulation, range of motion, communication and other needs." *Essential Functions number 5. "Provides care that maintains each Guests [residents] skin integrity to prevent pressure ulcers, skin tears and other damage by changing incontinent Guests [residents], turning, repositioning immobile Guests [residents] and by applying moisturizers to fragile skin and other areas." 8. Review of the provider's abuse and neglect policy revealed: *Neglect definition, "Neglect is the failure to provide necessary and adequate (medical, personal, or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service."	F 600		