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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING ______ B. WING ______	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

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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 1/7/24 through 1/9/24. Avantara Pierre was found not in compliance with the following requirements: F561, F625, F655, F684, F692, F695, F732, F761, F803, F812, F835, F849, and F865. A complaint facility-reported incident (FRI) investigation for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/7/24 through 1/9/24. The area surveyed was the provider's process for following residents' medical care instructions. Avantara Pierre was found to have past non-compliance at F678 for failure to follow a resident's medical care instructions regarding their resuscitation code status.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561	1. No immediate corrective action could be taken for the failure to accommodate resident's 33 clothing, activity, and mealtime preferences. 2. All residents have been identified to be at risk for staff failure to accommodate residents' clothing, activity, and mealtime preferences. 3. The Director of Nursing (DON) or designee will educate all care staff, to include certified nursing assistant (CNA) T, CNA U, and CNA W, on the Resident Dignity & Privacy policy to ensure resident's personal choices are considered when providing care and services to meet the resident's needs and preferences including clothing, activity, and mealtime preferences. Education will occur no later than February 20, 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.	02/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chase Watson
TITLE: Administrator
(X6) DATE: 02/08/2024

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 561	Continued From page 1 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to accommodate one of one sampled resident's (33) clothing, activity, and mealtime preferences. Findings include: 1. Observation and interview on 1/7/24 at 6:05 p.m. with resident 33 in her room revealed she: *Was in bed dressed in a hospital gown. *Waited for staff to help feed her the evening meal. -There was no reason why she had eaten meals in her room and stated she would have liked to have been asked by staff to go out to the main dining room and eat her meal. *Liked to play bingo and got a nickel when she won. Interview on 1/7/24 at 6:15 p.m. with certified nurse aide (CNA) T in resident 33's room revealed: *She was not aware why the resident was not eating in the dining room and had not known the resident wanted to be asked where she preferred to eat her meals.	F 561	4. The DON or designee will conduct an audit to observe 5 residents receiving care by care staff, including resident 33, to ensure resident's personal choices of clothing, activities and mealtime preferences are offered and accommodated. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the interdisciplinary team (IDT) and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

F 561 | F 561

Continued From page 2

-"We'll have to start taking you to the dining room [for meals] " but she had not offered to take the resident to the dining room that evening.

Random observations and interviews on 1/8/24 from 9:13 a.m. through 2:40 p.m. with resident 33 in her room revealed she:
*Was in her wheelchair dressed in a hospital gown at 9:13 a.m.
-Received an upper body massage from an unidentified hospice staff.
*Was fed her breakfast in bed by a staff member.
*Preferred to dress in her own clothing.
-Thought that staff might not have had time to assist her with dressing in her own personal clothes.
*Remained in a hospital gown in bed at 12:25 p.m. and was fed her noon-time meal by a staff member.
*Remained in a hospital gown in bed at 2:40 p.m.
-Had not been asked to play bingo that afternoon but stated she would have liked to attend that activity.

Interview on 1/8/24 at 3:00 p.m. with CNA U regarding resident 33 revealed:
*The resident had her own personal clothes to choose from to wear.
*She was not sure if the resident had asked to play bingo today but she knew that bingo was a favorite activity of the resident.

Interview on 1/8/24 at 5:30 p.m. with activity aide V regarding resident 33 revealed she:
*Knew the resident enjoyed playing bingo and sometimes her son accompanied her to that activity.
-Thought the resident was asleep at the time she went room-to-room earlier that day to remind the

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F 561	Continued From page 3	F 561		

residents about bingo.

Observations and interview on 1/9/24 at 8:15 a.m. and again at 9:15 a.m. with resident 33 revealed:
*At 8:15 a.m. she was asleep in bed with a hospital gown on
-A covered breakfast tray was on a nearby over-the-bed table.
*At 9:15 a.m. the resident was awake in bed drinking a beverage.
-She wore a hospital gown and had not been asked if she wanted to be dressed in her own personal clothes.
-She was not asked by any staff member about eating breakfast in the dining room.

Interview on 1/9/24 at 9:20 a.m. with CNA W regarding resident 33 revealed she:
*Had not offered to dress the resident in her own personal clothes that morning but agreed to ask the resident if she wanted her assistance to do so.
-The resident was overheard stating "Well I'd like to" after CNA W offered to assist her get dressed in her clothing.

Observation and interview on 1/9/24 at 9:40 a.m. with resident 33 revealed she:
*Was dressed in a pink top but only had an incontinence brief with no clothes on her lower extremities.
*Was not sure if staff had the time to get her up for the noon meal but she wanted to eat that meal in the dining room.

Review of resident 33's electronic medical record (EMR) revealed:
*Hospice interventions revised on 7/5/23:
-"[Resident 33] and family would like to have her

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F 561	Continued From page 4 up for one meal time each day. On Bingo days they would like her up for breakfast if she feels like she would like to eat with others M-W-F [Mondays, Wednesdays, Fridays]. And then up again in the afternoon for bingo." Interview on 1/9/24 at 2:30 p.m. with DON B regarding resident 33 revealed: *Staff were expected to consistently offer and assist the resident with dressing in her own personal clothing, eating her meals in the main dining room, and participating in bingo on the days it was offered. -Staff had not protected the resident's rights or promoted her personal preferences. Review of the September 2019 Resident Dignity and Privacy policy revealed: *"2. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences." *"6. Groom and dress residents according to resident preference." Interview on 1/9/24 at 10:30 a.m. with licensed practical nurse (LPN) E regarding resident 33 revealed: *She was gotten out of bed and taken to bingo when her son attended the activity with her. *LPN E stated the resident had "no quality of life staying in her room" and even though she was receiving hospice care "still needs stimulation."	F 561		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625	1.No immediate corrective action could be taken for the failure to ensure a Bed Hold Notice form was issued to resident 38 prior to her transfer to the hospital.	2/20/2024

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F 625	Continued From page 5 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure a Bed Hold Notice form was given to one of one sampled resident (38) prior to transfer to the hospital. Findings include: 1. Review of resident 38's electronic medical record (EMR) revealed: *On 6/17/23, she was transferred to the hospital when she had multiple episodes of vomiting with pain in her right lower abdomen.	F 625	2.All residents that are being transferred to the hospital are at risk for not receiving notification that their bed will be held prior to transfer. All residents and their representatives are at risk for not receiving written information that specifies a notice of transfer, the duration of the bed-hold, and the bed-hold payment policy. 3.The Administrator will educate the IDT, to include BOM O, and all licensed nurses on the Bed Hold Policy – South Dakota to ensure a Bed Hold Notice form is given to a resident prior to transfer to the hospital. In addition, the Administrator has created a tracking form to monitor the status of all bed holds to ensure all necessary notifications and documentation are completed. The Administrator will educate the IDT, to include BOM O on the newly developed tracking form and where to locate it. Education will occur no later than February 20, 2024. 4.The Administrator or designee will audit all residents' medical records that have had a facility-initiated transfer/discharge to ensure verbal and written notification of a bed hold occurred, to include an audit of the tracking log to ensure it is up to date. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly 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 625	Continued From page 6 The bed hold forms were requested from DON B on 1/9/24 at 9:00 a.m. for the above hospital transfer for resident 38 and the facility was not able to produce that documentation. Interview on 1/9/24 at 1:40 p.m. with licensed practical nurse (LPN) I revealed: *She usually worked the night shift. *If a resident was to have been transferred, they would have the resident sign a Bed Hold Notice form located at the nurse's station. *The form would then be placed at the nurse's station for the day shift to file in the resident's electronic medical record (EMR). *If the resident was not able to sign the form, the resident's name would have been written on the form and the day shift would "take care of it". Interview on 1/9/24 at 1:49 p.m. with LPN E revealed: *She usually worked the day shift. *If a resident was transferred, she would notify the resident's representative of the transfer. *She would then write a note in the EMR that a verbal notice was given to the resident's representative of the Bed Hold Notice and whether they would like the resident's bed held until return to the facility. *When asked what was done to get a signature on the Bed Hold Notice, she was not sure of that process. Review of resident 38's EMR progress notes for the date of transfer to the hospital and the following days revealed there was no documentation of a verbal Bed Hold Notice. Interview on 1/9/24 at 2:15 p.m. with social services designee H revealed she was not	F 625		

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responsible for the Bed Hold Notice; business office manager (BOM) O was.

Attempted to interview BOM O after the above interview and she was not available and was out of the facility.

Interview on 1/9/24 at 2:28 p.m. with administrator A revealed:
*BOM O had run to the hospital to follow up with a resident that had been transferred there.
*The nursing staff was responsible for obtaining the Bed Hold Notice forms for residents that were transferred before BOM O was hired.
-BOM O had been hired on 9/19/23.
*The floor nurse would have been responsible for getting the resident's or their representative's signature.
*BOM O would have been responsible for getting the resident's signature or the resident representative's signature on those forms.
*He would expect that if the floor nurse documented a verbal Bed Hold Notice that BOM O would follow up to get the form signed.

Interview on 1/9/24 at 3:18 p.m. with DON B revealed:
*She noticed that since BOM O had taken over the responsibility of the Bed Hold Notice that they had been getting consistently signed.
*She explained that they had recently had a nursing staff meeting regarding the correct procedure for obtaining a Bed Hold Notice.
*She would expect that if the nurse was to get a verbal Bed Hold Notice from a resident or the resident's representative, that the nurse would follow up with BOM O.

Review of the provider's undated "Bed Hold

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F 625	Continued From page 8 Policy-South Dakota" revealed: *"Per federal regulations, the facility is mandated to give you notice of transfer/discharge for facility-initiated transfers/discharges." *"When a resident is temporarily absent, the facility will automatically hold the resident's bed according to the regulations of that resident's current method of payment."	F 625		
F 655 SS=D	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 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	F 655	1. No immediate corrective action could be taken for the failure to establish a baseline care plan for residents 6 and 157 within 48 hours of admission and was reviewed with the resident, their representative, or their responsible family member. 2. All newly admitted residents are at risk for lack of establishing a baseline care plan within 48 hours of admission that is reviewed with the resident, their representative, or their responsible family member. 3. The Director of Nursing or designee with educate the IDT, to include SSD H and MDS coordinator D, on the Care Planning policy to ensure that a baseline care plan is established for all new residents within 48 hours of admission and is reviewed with the resident, their representative, or their responsible family member. Education will occur no later than February 20, 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.	02/20/2024

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F 655	Continued From page 9 (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 ensure two of two recently admitted sampled residents (6 and 157) had a baseline care plan that was established within 48 hours of admission and reviewed with the resident, their representative, or their responsible family member. Findings include: 1. Review of resident 6's electronic medical record (EMR) revealed: *She was admitted on 8/30/23. *There was a "Nursing-Admission/Readmission" assessment that was completed on 8/30/23. *Within the first 48 hours after she was admitted to the facility, the following was the only information included in her baseline care plan: -"I am at risk for alteration in nutritional status related to: Dementia. Date Initiated: 8/30/23." --There were no goals or interventions associated with that focus area until 9/6/23. -The rest of her care plan was not developed until 9/6/23, a week after she was admitted.	F 655	4. The DON or designee will conduct an audit of all newly admitted residents to ensure a baseline care plan has been established within 48 hours of admission and was reviewed with the resident, their representative, or their responsible family member. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly 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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*There was no indication in her EMR that a baseline care plan was developed or shared with the resident, her representative, or her responsible family member.

2. Interview on 1/8/23 at 4:50 p.m. with Minimum Data Set (MDS) coordinator D about newly admitted resident's baseline care plans revealed:
*The nurse performing the admission assessment was responsible for initiating the baseline care plan.
*The last section of the "Nursing-Admission/Readmission" assessment was designated for selecting care areas to include in the care plan.
*She was unsure why resident 6's care plan had not been initiated even though the care areas were selected on the admission assessment.
*The social services designee was responsible for printing the baseline care plan to share with the resident, their representative, or their family member.

Interview on 1/8/24 at 5:00 p.m. with social services designee (SSD) H and administrator A about baseline care plans revealed:
*SSD H was new to her position since September 2023.
*Administrator A explained that since SSD H was still in training, the responsibility to ensure baseline care plans were completed as the responsibility of the MDS coordinator.

Continued interview on 1/9/24 at 11:04 a.m. with administrator A about resident's baseline care plans revealed:
*He confirmed he could not find evidence that a baseline care plan was developed and shared with resident 6, her representative, or her family.

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F 655	Continued From page 11 *It was his expectation that baseline care plans should have been developed within the first 48 hours after a resident was admitted to ensure staff knew how to care for the resident. *He confirmed that resident 6's care plan was not developed until 9/6/23, which was a week after she was admitted. *He again confirmed the MDS nurse would have been the responsible party to ensure baseline care plans were developed and shared with the resident, their representative, or their families. 3. Review of resident 157's EMR revealed: *He was admitted on 1/4/24. *Several focus areas on his care plan were non-specific, incomplete, or had not been edited to account for the resident's needs. Examples included: -"(Interim) Resident is at risk for fluctuating blood sugars due to diabetes mellitus." There was no associated goal with that focus area. -"(Interim) Resident has (Specify: potential for/an actual) impairment to skin integrity." -"(Interim) Resident requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)." There were no associated interventions describing how the resident needed to be assisted with his ADLs. -"(Interim) Resident is at risk for alteration of bowel and bladder functioning related to: [Specify: Dementia, Catheter use (Foley, Suprapubic, Intermittent), Colostomy/Ileostomy, Urostomy]." --The resident did not have any sort of catheter, nor did he have an ostomy. -"(Interim) Resident is at risk for alteration in nutritional status related to: (Specify: Therapeutic diet, Tube feeding, NPO [nil per os, meaning nothing by mouth], Behavior problems, other:	F 655		

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specify)." There was no associated goal for that focus area.
--The resident was not receiving tube feedings, he was not NPO.
--The interventions were not specific about at his diet order was.
*There was no indication in his EMR that his baseline care plan was discussed with or provided to the resident, his representative, or a family member.

4. Interview on 1/9/24 at 3:07 p.m. with MDS coordinator D about resident's baseline care plans revealed:
*The baseline care plan should have included the resident's initial goals, such as physical or occupational therapy goals.
*The nurses were responsible for updating the care plan with items such as how the resident transfers, their diet order, and their long-term goals.
*When asked how resident 157 was supposed to transfer, she said, "I don't know because it's supposed to be on the care plan." She confirmed that the information was not on his care plan.
*She confirmed that it was her responsibility to ensure the baseline care plans were completed and shared with the resident, their representative, or their family member.

5. Review of the provider's September 2019 "Care Planning" policy revealed:
*"POLICY: 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:"
-"3. Care planning is constantly in process; it

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F 655	Continued From page 13 begins the moment the resident is admitted to the facility and doesn't end until discharge or death." -"4. Each resident is included in the care planning process ..." -"5. The DON [director of nursing] will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours ..." *Under the "Procedure" section: -"2. 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, Therapeutic Recreation and Social Services staff complete formal assessments, interviews and observation 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)." -"3. The areas that must be addressed in the base line care plan include:" --"a.) Initial goals based on admission orders." --"b.) Services and Treatments being provided." --"c.) Summary of Medications." --"d.) Dietary Instructions." --"e.) Ongoing update to the initial care plan." -"4. ... Resident care conferences are held within the first 72 hours of admission ... Resident/Resident Representative will be invited to the care conference." -"4. [#4 is listed twice] During the care conference the care plan is reviewed with the resident and/or resident's representative. The resident and/or the resident's representative will be asked to sign the care plan signature page to indicate that they had reviewed the care plan."	F 655		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR)	F 678	Past noncompliance: no plan of correction required.	

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CFR(s): 483.24(a)(3)

§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, review of a facility-reported incident (FRI), and policy review, the provider failed to ensure one of one closed record sampled resident (258) with a do not resuscitate (DNR) code status who had no pulse or respirations when found by staff had not received cardiopulmonary resuscitation (CPR).
Findings include:

1. Review of resident 258's closed electronic medical record (EMR) revealed his:
*Admission date was 12/5/23 and he was 91 years old.
*Medical history included an acute bilateral subdural hematoma (bleeding on the brain).
*"Resuscitation Designation Order" form signed on 12/5/23 by business office manager O, the resident's representative, and the resident's physician indicated his resuscitation code status was a DNR.

Review of the FRI submitted by administrator A to the South Dakota Department of Health on 1/4/24 revealed:
*On 1/4/2024 at 12:25 a.m. certified nurse aide R (CNA) answered resident 258's call light and straightened his urinary catheter bag from under his leg.
-He voiced no other concerns.

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F 678	Continued From page 15 *At 12:43 a.m. registered nurse (RN) M found the resident with no respirations and no palpable carotid pulse during her routine rounds. -She called for assistance from RN N at 12:44 a.m. *RN N and CNA S lowered the resident to the floor and RN N began CPR at 12:45 a.m. *Paramedics arrived at 12:48 a.m. and took over CPR. *RN M notified director of nursing (DON) B, the resident's physician, and the resident's power of attorney of his change in condition between 12:48 a.m. and 12:52 a.m. *At 1:00 a.m. RN M reviewed the resident's paper chart. -His Resuscitation Designation Order form indicated his resuscitation code status was a DNR. *CPR was stopped. Review of the 3/1/22 Deceased Note without CPR policy revealed: "1. CPR will be conducted on a resident/patient that has a witnessed respiratory or cardiac arrest unless the resident has documented that CPR not be performed via a properly executed health care directive, DNR [do not resuscitate] statement." Interview on 1/7/24 at 6:15 p.m. with RN N regarding the FRI referred to above revealed she: *Confirmed the information referred to above from the 1/4/24 FRI report. *Knew to look behind the Resuscitation Tab in the resident's paper chart or refer to their EMR to obtain the resident's resuscitation code status. -Presumed RN M had verified resident 258's resuscitation code status before initiating CPR. Interview on 1/7/24 at 6:30 p.m. with DON B	F 678		

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regarding the FRI referred to above revealed:
*RN M failed to confirm resident 258's resuscitation code status in either his EMR or paper chart before instructing RN N to initiate CPR.
*On 1/4/24 DON B reviewed the incident referred to above with the overnight staff and what should have been done.
-She re-educated other caregivers in the days that followed the incident the expected process to follow if a resident is found without a pulse or respirations.

Review of the provider's "Teachable Moment (re-education documentation) Form" associated with the FRI revealed:
*"Observation [Behavior to Change]:
-CPR was initiated on a resident who had a DNR signed and uploaded into PCC [the name of the electronic documentation program for the EMR called "Point, Click, Care"]. Signed document was also on the hard chart [paper chart] at the nurses station."
*Re-education included the following topics:
-Resuscitation orders for new resident admissions.
-How resuscitation code status information was obtained and entered into a resident's paper chart and EMR.
-Steps to have taken upon identifying a resident without respirations and no pulse.
-Review of the facility's Resuscitation policy.

The survey team determined there was a deficient practice on 1/4/24 when RN M instructed RN N to initiate CPR for resident 258 without first having verified his resuscitation code status. The surveyor was able to verify the provider recognized the deficient practice, implemented

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F 678	Continued From page 17 corrective actions beginning on 1/4/24 and was monitoring to ensure no re-occurrence of the previous deficient practice occurred.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Monitor and implement bowel management interventions for one of one sampled resident (50) who received hospice services. *Provide appropriate duration and meaningful activities to maintain the well-being for one of one sampled resident (8) with unique psychosocial needs. Findings include: 1. Random observations of resident 50 in her room throughout the survey revealed: *On 1/7/24 at 2:45 p.m. she was in bed with her eyes closed. *On 1/8/24 at 9:15 a.m. she was in bed with her eyes closed. -At 12:25 p.m. she fed her noon meal by staff in bed. -At 2:40 p.m. she was in bed with her eyes closed.	F 684	1. Licensed practical nurse (LPN) E completed a bowel assessment on resident 50 upon discovery during the survey on 1/9/24 and administered a prn laxative per physician's order. No immediate correction action could be taken for the failure to provide appropriate duration and meaningful activities to maintain the well-being of resident 8 with unique psychosocial needs. 2. All residents have been identified to be at risk for not being monitored to ensure appropriate bowel interventions have been implemented when indicated. A full house audit of all residents was completed on January 18, 2024, to ensure that bowel management interventions have been implemented for any resident that has not had a bowel movement for 3 days or greater. All residents with unique psychosocial needs are risk for not being provided appropriate duration and meaningful activities to maintain their well-being. A full house audit of all residents with unique psychosocial needs will be conducted to ensure they are being provided duration and meaningful activities to maintain their well-being no later than February 20, 2024.	02/20/2024

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*On 1/9/24 at 8:15 a.m. she was in bed with her eyes closed.
*The resident was non-verbal during the above observations and displayed no indications that she was in pain.

Review of resident 50's electronic medical record (EMR) revealed:
*Her diagnoses included Alzheimer's disease, stroke, dysphagia, and severe protein-calorie malnutrition.
*An 8/23/23 physician's order for admission to hospice services.
*Her last documented bowel movement was on 12/31/23 and it was described as being "small."
*Her percentage of meals consumed between 12/31/23 and 1/8/24 revealed she had eaten:
-0-25% of her documented meals 17% of the time.
-26-50% of her documented meals 22% of the time.
-51-75% of her documented meals 39% of the time.
-76-100 % of her documented meals 22% of the time.
*Nurse progress notes between 12/31/23 and 1/8/24 revealed no documentation the resident had not had a bowel movement during that time.
*Documentation behind the "Hospice" tab in the resident's paper chart revealed only a Care Plan Summary dated 8/23/23 through11/20/23.

Review of resident 50's November 2023 through 1/8/24 Medication Administration Records (MARs)revealed she:
*Received scheduled acetaminophen for pain on a daily basis.
*Had a physician order for PRN (as needed) suppository or PRN Senna (medications used to

F 684

3. The DON and the Medical Director has developed a bowel protocol for the facility to ensure appropriate bowel interventions are implemented for residents that have not had a bowel movement for 3 days or greater. The DON or designee will educate all nursing staff on the newly developed bowel protocol to ensure appropriate bowel interventions are implemented for residents that have not had a bowel movement for 3 days or greater. The DON and the IDT will review all residents that trigger for not having a bowel movement for 3 days or greater during their morning clinical meeting to ensure appropriate bowel interventions are implemented. The Administrator or designee will educate the activities director G, the activity aides, and all nursing staff on the Activities policy to ensure residents with unique psychosocial needs are provided with duration and meaningful activities to meet their well-being. Education will occur no later than February 20, 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.
4. The DON or designee will conduct an audit of 5 residents' bowel records and their medical record to ensure appropriate bowel interventions have been implemented if resident has not had a bowel movement for 3 days or greater. The Administrator or designee will conduct audits of 5 residents with unique psychosocial needs to ensure they are provided with duration and meaningful activities to maintain their well-being. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator, DON, or designee at the monthly 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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treat constipation) but those medications had not been administered since November 2023.

Interview on 1/9/24 at 8:15 a.m. with licensed practical nurse (LPN) E regarding a resident bowel protocol revealed:
*Certified nurse aides (CNA) were responsible for documenting residents' bowel movements in Point, Click, Care (PCC-the provider's computerized healthcare documentation system).
-A visual "alert" appeared on the nurses' PCC "dashboard" when a resident was without a documented bowel movement for three days.
*The nurse was then responsible for the following:
-Assessing the resident's abdomen and listening for bowel sounds.
-Administering a medication used to treat constipation and waiting for results achieved.
-Initiating additional bowel interventions if there were no initial results after administering the constipation medication.
-Contacting the resident's physician if needed.
*There was no written facility or hospice bowel protocol.

Continued interview with LPN E regarding resident 50's bowel status revealed:
*"We watch it pretty close."
*She was not aware of the resident's last documented bowel movement that was on 12/31/23.
-There was no alert on her PCC dashboard that indicated she was without a bowel movement for three days.

Observation on 1/9/24 at 10:15 a.m. of LPN E's assessment of resident 50 revealed:
*She heard active bowel sounds and the

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F 684	Continued From page 20 resident's abdomen was soft and not tender to touch. *Her follow-up plan was to discuss her findings with director of nursing (DON) B and administer a PRN medication for constipation. -The resident was unable to confirm she had regular bowel movements due to her impaired cognitive status. Interview on 1/9/24 at 9:36 a.m. with DON B regarding resident 50's bowel status revealed she: *Was not sure why LPN E's PCC dashboard had not alerted her that the resident had no documented bowel movement in over three days. -"Can you give me a minute to look into it?" Follow-up interview on 1/9/24 at 2:06 p.m. with DON B revealed: *Her PCC dashboard showed it had been over three days since resident 50 had a documented bowel movement but she was not sure why LPN E had not received that same alert. *"I know she [resident 50] had to have gone [had a bowel movement]. If she hasn't had a BM [bowel movement] she won't eat." -She thought a CNA probably failed to document a bowel movement or hospice failed to report the resident having had a bowel movement. A Bowel Protocol policy was requested of DON B on 1/9/24 at 3:40 p.m. She indicated the facility had no Bowel Protocol policy. It was expected nursing staff administered medication for constipation per physician's order after three days if a resident had no BM. 2. Observation on 1/7/24 at 3:00 p.m. and again at 4:20 p.m. of resident 8 revealed: *The door to her room was opened halfway.	F 684		

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*Her room was dark with the window shades pulled with no light coming through.
*Her bed was pushed up against the wall and in a low position with a fall mat lying on the floor in front of the bed.
*Her wheelchair (w/c) was placed in front of the closet door.
*The walls were bare, with a bedside table at the end of her bed.
*The resident was sleeping in her bed with the blankets pulled over her head.
*The resident was the only one occupying the room.

Observation on 1/8/24 at 10:00 a.m. of resident 8 revealed:
*The door to her room was opened halfway.
*Her lights were off but minimal light was coming through the window.
*Her bed was pushed up against the wall and in a low position with a fall mat lying on the floor in front of the bed.
*Her w/c was placed in the far corner of the room.
*The resident was sleeping in her bed with the blankets pulled to her chin.

Review of resident 8's electronic medical chart (EMR) revealed:
*A Brief Interview for Mental Status (BIMS) of 5, indicating severe cognition impairment.
*She had a diagnosis of major depressive disorder, dysphasia, hemiplegia, hemiparesis, alcohol dependence, nontraumatic intracerebral hemorrhage, unspecified psychosis, and history of transient ischemia attack (TIA).
*Her psychotropic medications included: Risperdal 0.5 milligrams (mg) by mouth three times a day, and Sertraline HCl (hydrochloride) 200 mg at bedtime.

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Interview on 1/8/24 at 1:39 p.m. with a staff member who requested to remain anonymous regarding resident 8 revealed:
*Resident 8 had been eating in the activities/dining room area by herself with very little to no staff assisting or sitting with her.
*The staff had been told they were to have been directing resident 8 back down her hallway away from the other resident's hallway that she had gotten into the altercations with.
*Resident 8 was usually in her room or the activities/dining room area.
-Resident 8 had not participated in group activities.
*At times would see resident 8 looking out the large window in the activities/dining room area.

Interview on 1/8/24 at 2:53 p.m. with activities director G regarding resident 8 revealed she:
*Had been the activities director for three years.
*The activity aides spent 15 minutes three times a week with resident 8 in her room.
-The resident enjoyed music, having her hair combed, having lotion put on her hands, any art or craftwork, or simply having a conversation.
*Attempted to spend two days a week, 15 minutes each time with resident 8.
-The resident had not spent a lot of time in bed, she was usually in the activities/dining room area looking out the large window.
*When resident 8 attended a group activity, she would have a staff member sit with her.

Interview on 1/9/24 at 10:39 a.m. with director of nursing B regarding resident 8 revealed she:
*They encouraged staff to have one-to-one time with the resident.
-Two years ago they hired a staff member to

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F 684	Continued From page 23 come and sit with the resident but her behavior worsened and she attempted to stab the staff member with a crayon. *The staff had attempted to place the resident in the bigger dining room at multiple tables but she would punch other residents. *Had staff complete the new hire and annual trainings that included residents with unique needs. -The Ombudsman presented a training to the staff on dementia. -Had the staff complete an online training on schizophrenia. *Had trained the staff on how to approach the resident. Interview on 1/9/24 at 11:23 a.m. with a staff member who requested to remain anonymous regarding resident 8 revealed: *Staff were instructed by administration to keep the resident down her hallway and not to let her pass the double doors. *The resident had not participated in any group activities. *It was the resident's choice to return to bed. -The resident had been sleeping more the past six months. *The resident used to be 1:1 but not anymore and she was not sure why. *The resident was eating in the activities/dining room area by herself and she was able to feed herself. Interview on 1/9/24 at 11:30 a.m. with a staff member who requested to remain anonymous regarding resident 8 revealed: *The resident could have gone to the main dining room more often but that the resident started throwing fits when she was in the main dining	F 684		

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	435047	A. BUILDING ______ B. WING ______	C 01/09/2024

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F 684	Continued From page 24 room. *Staff felt the resident knew what she was doing when she threw those fits. *She probably could have gone to more activities if they had more staff for the 1:1 support. *It was the resident choice to go back to bed after her meals. Review of resident 8's EMR revealed: *Her 1/5/24 care plan had no documentation of any activities listed for likes or dislikes. *Care conferences held on 7/10/23 and on 10/10/23 under recreation summary documentated concerns that the resident continued to be restricted to her room and ACU due to her physical aggression toward other residents. -Care conference on 10/10/23 documented that there was not enough activity staff to bring her to group activities as she required 1:1 supervision. *Activity evaluation's dated on 6/29/23, 10/31/23 and 11/3/23 under the assessment summary had mentioned resident 8 continues to be restricted to her room and ACU due to physical aggression toward other residents. She was able to come to group activities as long as she was accompanied by a staff member. -The activity evaluation's on 11/3/23 and on 10/31/23 under resident leisure functioning if other explain it documented that due to the aggressive behaviors the resident was not allowed to participate in activities unless she had 1:1 supervision.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692	1. Resident 21, her representative, her provider, and the RD has been notified of resident's current weight and she is not triggering for a significant weight loss.	02/20/2024

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F 692	Continued From page 25 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the resident, their representative, physician, and a registered dietitian (RD) had been notified of a significant weight loss for one of one sampled resident (21). Findings include: 1. Review of resident 21's weight history revealed: *On 9/12/23, she weighed 316.6 pounds (lbs.). *On 10/9/23, she weighed 320.6 lbs. *There were no weights recorded in November 2023. *On 12/6/23, she weighed 321.4 lbs. *On 12/30/23, she weighed 321.3 lbs. *On 1/2/24, she weighed 301.8 lbs., which was a 19.5 lbs. and 6.32% (percent) weight loss in 3 days.	F 692	2. All residents are risk for the failure to be notified of a significant weight loss, along with failure to notify their representative, physician, and a RD. A full house audit was completed on January 18, 2024, to identify all residents with a significant weight change to ensure resident, resident representative, physician and RD have been notified. 3. The Administrator, DON, and IDT in collaboration with the governing body reviewed the Weighing the Resident policy and the Notification of Change of Condition policy to ensure resident, resident representative, physician, and RD are notified of significant weight changes. The DON and designee will educate all nursing staff on the Weighing the Resident policy and the Notification of Change of Condition policy to ensure resident, resident representative, physician, and the RD have been notified of significant weight changes. The DON and IDT will track all residents triggering for a significant weight change during their daily clinical meeting to ensure resident, resident representative, physician, RD have been notified. Education will occur no later than February 20, 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. 4. The DON or designee will conduct an audit of 5 residents' weight record and medical record to ensure that the resident, resident representative, physician, and RD has been notified of any significant weight change. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly 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 692	Continued From page 26 *On 1/4/24, she weighed 301.7 lbs. Review of resident 21's electronic medical record revealed: *There was no indication that the resident, her representative, her primary care physician, or an RD was notified about the significant weight loss. 2. Interview on 1/9/24 at 9:10 a.m. with director of nursing (DON) B about resident 21's significant weight loss revealed: *When a resident's weight was entered into their electronic medical record, the program calculated the percent weight loss, and the nurse received a warning if there was a significant weight loss. *The first thing the nurse should have done was perform a reweigh on the resident if there was a significant weight loss to confirm the resident's current weight. *She confirmed that a staff member had performed a reweigh for resident 21 on 1/4/24. *She explained that resident 21 experienced fluid imbalance issues. -Resident 21 had a diagnosis of edema. -She was prescribed a diuretic. *She indicated that the diuretic would not necessarily cause that drastic of a weight loss in three days. Interview on 1/9/24 at 9:24 a.m. with licensed practical nurse (LPN) E about resident weight loss revealed: *The management team met each day at "stand up," which included discussions of weight loss. *If she noticed a weight loss in a resident, she would have first obtained a reweigh to confirm the resident's current weight. *She would have informed the charge nurse about the significant weight loss.	F 692		

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F 692	Continued From page 27	F 692		

*The charge nurse was to inform the physician and the RD about the significant weight loss.
*She confirmed that no one was notified about resident 21's significant weight loss.

Interview on 1/9/24 at 9:26 a.m. with LPN F about resident 21's weight loss revealed:
*She reweighed the resident that morning. The resident was at 306.8 lbs.
*She confirmed that the resident's doctor had not been notified of the significant weight loss when he should have been notified.

3. Review of resident 21's care plan revealed:
*There was a focus area that read, "I am at potential nutritional risk [related to] receiving a therapeutic [consistent carbohydrate] diet [related to] [type 2 diabetes mellitus]. I am obese [as evidenced by] [body mass index] of [greater than] >45. Gradual therapeutic [weight] loss is encouraged and physician-prescribed [related to] diuretic use and reduced [calorie] diet in place. I have a [history] of significant [weight] fluctuations [related to] fluid shifts, edema, and [history] of cellulitis."
-Date Initiated: 3/17/20.
-Revision on: 6/5/22.
*There was a related goal that read, "Gradual [weight] loss of 0.5-2 [pounds per week]."
-Date Initiated: 3/26/20.
-Revision on: 12/19/23.
-Target Date: 2/12/24.
*Her care plan indicated she had diabetes mellitus.
-There was an intervention that read, "Observe for and report to my physician any signs/symptoms of hyperglycemia: ...weight loss ..."
-Date Initiated: 3/30/20.

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F 692	Continued From page 28 -Revision on: 8/24/22. *Her care plan indicated she was at risk for dehydration or potential fluid deficit. -There was an intervention that read, "Observe for and report to my physician any [signs or symptoms] of dehydration: ...recent/sudden weight loss ..." -Date Initiated: 6/5/22. -Revision on: 8/24/22. *Her care plan indicated she was on an antidepressant and an antipsychotic medication that had the potential to affect weight. -There was an intervention associated with the antidepressant that read, "Observe me and report to my physician any ongoing [signs or symptoms] of depression unaltered by antidepressant meds: ...changes in weight/appetite ..." -Date Initiated: 9/6/23. -Revision on: 9/6/23. -There was an intervention associated with the antipsychotic that read, "Observe for and report to my physician any side effects and adverse reactions of psychoactive medications: ...weight loss ..." -Date Initiated: 3/18/20. -Revision on: 8/24/22. Review of the resident's diagnoses list revealed the following relevant diagnoses: *"EDEMA, UNSPECIFIED." *"GENERALIZED EDEMA." *"MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES." Review of the resident's physician's orders that potentially could have affected weight revealed: *"Apply tenso shapes to bilateral lower legs on in the [morning] and remove at [bedtime]."	F 692		

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F 692	Continued From page 29 -The order was scheduled for "every day shift." -Ordered on 8/4/20, started on 8/5/20. *"Apply tenso shapes to bilateral lower legs on in the [morning] and remove at [bedtime]." -The order was scheduled for "every evening shift." -Ordered on 8/4/20, started on 8/5/20. *"Furosemide Tablet 80 [milligrams] Give 80 mg by mouth two times a day for Edema related to ESSENTIAL (PRIMARY) HYPERTENSION (I10); GENERALIZED EDEMA (R60.1); CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE (I50.22)." -Ordered on 3/9/21, started on 3/10/21. 4. Review of the provider's 4/3/21 "Weight Management Guidelines" revealed: *"Policy: ...Residents with significant weight variance should be identified and appropriate intervention implemented." *Under the "Procedure" section: -"2. .....Be sure to re-weigh when there is a weight variance of plus or minus 5 pounds.......Where computerized weight variance programs are used the community should assign responsible parties to input the weights." -"5. Suggested parameters for evaluating significance of unplanned and undesired weight loss/gain are: --Interval: 1 week. Significant Loss/Gain: 2 - 3 %. Severe Loss/Gain: Greater than 3%." -"7. A 'Medical Nutrition Review' or other designated form should be completed within 72 hours of identification in the event of a significant loss in weight/gain in one month, three months, or six months. This should be....completed and assessed by the RD. In the Nutrition Risk Review process, identify why weight loss/gain occurred and intervene accordingly."	F 692		

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F 692	Continued From page 30 -"8. Nursing should notify the physician and family of significant or severe weight loss." -"12. Insidious weight loss/gain can be a nutritional concern when unplanned. Be aware of this type of weight loss/gain and intervene even when the weight loss/gain is not significant."	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the provider failed to clean one of one sampled resident's (210) nebulizer mask after providing and aerosol treatment. Findings include: 1. Observation on 1/8/24 at 10:50 a.m. of licensed practical nurse (LPN) E while performing resident 210's nebulizer treatment revealed she: *Removed the nebulizer mask from the resident's face after the treatment was completed. *Placed the mask on the resident's nebulizer machine. *Did not rinse and disinfect the mask after the treatment was completed. Interview on 1/9/24 at 11:36 a.m. with infection prevention/licensed practical nurse (LPN) F	F 695	1. The nebulizer mask was immediately cleaned by infection prevention/licensed practical nurse (LPN) F immediately upon discovery during survey on 1/9/24 prior to the next nebulizer aerosol treatment being administered. 2. All residents who receive a nebulizer aerosol treatment are at risk for failure to clean their nebulizer mask after providing an aerosol treatment. 3. The DON or designee with educate all licensed nurses on the Nebulizer Cleaning policy to ensure that the nebulizer mask is cleaned after each nebulizer aerosol treatment is administered to a resident. Education will occur no later than February 20, 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. 4. The DON or designee will conduct an audit of 5 residents receiving nebulizer aerosol treatments to ensure their nebulizer mask is cleaned after an aerosol treatment has been administered. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	02/20/2024

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F 695	Continued From page 31 regarding the above observation revealed she would have expected that the staff would have rinsed the nebulizer mask after the treatment was completed. Interview on 1/9/24 at 3:18 with director of nursing (DON) B revealed: *She would have expected the staff to follow the nebulizer policy which includes rinsing and disinfecting the nebulizer mask after nebulizer treatments were completed. Review of the provider's undated "ORAL INHALATION ADMINISTRATION" policy revealed: *"NEBULIZER" *"U. Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations"	F 695		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732	1. No immediate corrective action could be taken for the failure to ensure daily staff information was consistently posted. 2. All residents are risk for the failure to ensure daily staff information is being consistently posted. 3. The Administrator will educate the DON, MDS coordinator D, and the IDT on the Posting of Daily Staffing policy to ensure daily staff, to include registered nurses (RNs), LPNs and CNAs, information is consistently posted. The posting of the daily staff information will be reviewed during morning meeting to ensure it is being posted consistently. Education will occur no later than February 20, 2024.	02/20/2024

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F 732	Continued From page 32 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure daily staffing information was consistently posted. Findings include: 1. Observation on 1/7/24 revealed: *At 2:00 p.m. the staffing information that was posted was for 1/5/24. *At 5:30 p.m. the posted staffing information referred to above was replaced with updated staffing information for 1/7/24. Interview on 1/7/24 at 5:30 p.m. with Minimum Data Set (MDS) coordinator/registered nurse (RN) D regarding the posted staffing information referred to above revealed she: *Had removed the 1/5/24 posted nurse staffing information at about 2:30 p.m. and replaced it	F 732	4. The Administrator or designee will conduct an audit of the daily staff posting 5 days per week to ensure daily staff information is consistently posted. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly 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 732	Continued From page 33	F 732		

with nurse staffing information for 1/7/24.
*Was responsible for posting daily staffing information.
-Nursing staff were responsible for updating her posted staffing information each shift with any staffing changes such as a staff member calling out for their scheduled shift.

Continued interview and review of the daily staffing information posted between 12/15/23 and 1/7/24 revealed:
*No staffing information was posted from 12/29/23 through 12/31/23, or on 1/1/24, 1/2/24, and 1/6/24.
-MDS coordinator/RN D had been on leave during that time and administrator A was responsible for posting the daily staffing information.

Interview on 1/8/24 at 2:00 p.m. with licensed practical nurse E regarding the daily staffing information revealed she was not:
*Involved in the completion or updating of the daily staffing information form.
*Aware of who was responsible for completion of that form but thought it might have been the night nurse.

Interview on 1/8/24 at 3:00 p.m. with administrator A revealed in the absence of MDS coordinator/RN D, the posting of staffing information was DON B's responsibility.

Interview on 1/8/24 at 3:15 p.m. with DON B regarding the daily posting of staffing information revealed she:
*Was responsible for having posted staffing information during MDS coordinator/RN D's absence referred to above.

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F 732	Continued From page 34 -Was not aware staffing information was not available for the dates referred to above. *Expected nursing staff to complete the daily staffing information for the dates referred to above when neither she nor the MDS coordinator/RN D were available. Review of the 6/1/23 Posting of Daily Staffing policy revealed: *"2. The facility will post the nursing staffing total number prior to each shift." *"4. After the start of each shift, actual hours will be updated if there are any changes to the schedule/number of staff/hours worked."	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761	1. DON immediately educated LPN E upon discovery during survey on 1/8/24 to ensure medications are secured by locking the medication cart and resident's personal information is to be secured on the computer while sitting on the medication cart when left unattended. 2. All residents are at risk for the failure to ensure medications are secured in a locked medication cart and their personal information is secured on the computer when the medication cart it is left unattended. 3. The DON or designee will educate all licensed nurses on the Medication Storage – Storage of Medication policy and the Medication Administration – General Guidelines policy to ensure medications are secured by locking the medication cart and resident's personal information is secured on the computer when the medication cart is left unattended. Education will occur no later than February 20, 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.	02/20/2024

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F 761	Continued From page 35 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Resident medications were secured in one of two medication (med) carts that was left unattended and unlocked by the staff member administering meds. *Resident's personal information was secured on the computer that was sitting on the med cart. Findings include: 1. Observation and interview on 1/8/24 at 10:45 a.m. with licensed practical nurse (LPN) E revealed: *The med cart was located in the hallway outside of a resident's room. *The med cart computer screen was opened to a resident's electronic medical record (EMR). *She was administering a nebulizer treatment for two residents who were roommates in their room. *The med cart was unlocked. *The med cart contained meds for all the residents that resided in that hallway. *The director of nursing (DON) B observed the surveyor opening the drawers of the medication cart and requested that LPN E come out to the medication cart and speak with her. *LPN E agreed that she should have locked the med cart and the computer screen when she walked away to administer the nebulizer treatments. Interview on 1/9/24 at 3:18 p.m. with DON B revealed she agreed that the med cart should	F 761	4. The DON or designee will audit 5 medication administrations by a nurse to ensure medications are secured by locking the medication cart and resident's personal information is secured on the computer when the medication cart is left unattended. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly 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 761	Continued From page 36 have been locked and the computer screen secured when LPN E walked away from the med cart. Review of the provider's undated "MEDICATION STORAGE IN THE FACILITY" policy revealed: *"Procedures" *"B." *"Medication rooms, carts and medication supplies are locked when not attended by persons with authorized access." Review of the provider's undated "MEDICATION ADMINISTRATION-GENERAL GUIDELINES" policy revealed: *"Procedures" *"D. Documentation (including electronic)" *"7 ... Electronic systems also describe procedures for secure access, maintaining privacy of resident information, and for and electronic signatures. Maintenance and support procedures for these systems are described in the system user manuals. Procedures will vary between the various electronic systems available."	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803	1. No immediate corrective action could be taken for the failure to follow the written menus for residents 5, 10, 13, 19, 25, 28, and 50, who received a pureed diet, and for resident 9 who received a mechanical soft diet with pureed meats. All scoops have been discarded and replaced with new ones according to the color-coded scoop guide. A color-coded scoop guide was placed in the kitchen for staff to reference. 2. All residents are at risk for the failure to follow written menus to ensure residents' meal requirements are met.	02/20/2024

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F 803	Continued From page 37 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and menu review, the provider failed to follow the written menus for seven of seven sampled residents (5, 10, 13, 19, 25, 28, and 50) who received a pureed diet, and one of one sampled resident (9) who received a mechanical soft diet with pureed meats. Findings include: 1. Observation and interview on 1/9/24 from 11:10 a.m. to 11:56 a.m. with cook J in the kitchen revealed: *He was placing pans of food into the steam table. *He placed a green-handled scoop into the pureed broccoli, a gray-handled scoop into the mashed potatoes, and a blue-handled scoop into the pureed pork chops. *He was not sure what the scoop sizes were because the scoop size number on the scoops had either worn away or was not visible, and there was no guide to associate the color of the	F 803	3. Regional Culinary Operations Director or designee will educate all dietary staff and the Administrator on the portion guide and how to know what scoop to use to meet the resident's menu requirements. A color-coded portion guide was obtained and posted in the kitchen for staff to reference to ensure the appropriate scoop size is used to meet the resident's meal requirements. Education will occur no later than February 20, 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. 4. Administrator or designee will audit the serving of 5 meals a week to ensure that all residents receive the appropriate portions according to their meal requirements. Audits will be weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

F 803 Continued From page 38 F 803

scoop handle with the serving size of the scoop.
*The resident tray tickets indicated their diet order and specified the food item serving sizes.
-Those residents who received a pureed diet were to have been served 4 ounces (oz.) (equates to 1/2 cup) of pureed pork, 4 oz. of mashed potatoes, and 2.67 oz. (equates to 1/3 cup) of pureed broccoli.
*Cook J used those same scoops throughout the meal service.

Interview on 1/9/24 at 1:09 p.m. with dietary manager P about the above observation revealed:
*She was unable to locate a color-coded chart for the scoops.
*She confirmed that:
-Cook J had used a blue scoop for the pureed pork.
-The blue scoops were "#8 scoops", which was 2 oz., or 1/4 cup.
-Those who received a pureed diet were not served the full 4 oz. serving of the protein for their meal. They were shorted by 2 oz. of pork.
-The correct size scoops were used for the pureed broccoli and mashed potatoes.
*It was her expectation for staff to check the menu, diet spreadsheet, and resident tray tickets to determine the correct serving sizes.

2. Review of the provider's "Daily Spreadsheet" for lunch on 1/9/24 revealed the following menu and serving sizes:
*"Glazed Pork Loin."
-Pureed diet was to receive a "#8" scoop of pureed pork.
*"Baked Potato."
-Pureed diet was to receive a "#8" scoop of mashed potatoes.

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F 803	Continued From page 39 *"Broccoli Almondine." -Pureed diet was to receive a "#12" scoop of pureed broccoli without the almonds. *The dietitian had signed off on the menu on 11/3/23.	F 803		
F 812 SS=F	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. §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: *Maintain the dishwasher, scoop storage drawer, ceiling ventilation fans, ceiling pipes, and floor drains in a clean and sanitary manner to prevent the buildup of crumbs, rust, grime, limescale, and dust. *Ensure one of three reach-in refrigerators was maintained at a temperature below 41 degrees	F 812	1.The dishwasher, scoop storage drawer, ceiling ventilation fans, ceiling pipes, and floor drains have been cleaned to ensure they are sanitary and free from buildup of crumbs, rust, grime, limescale, and dust. All temperature gauges are functioning appropriately. Two temperature gauges were placed in each refrigeration unit and were labeled A and B to ensure refrigerators are maintained at temperature of 41 degrees or below. The dishwasher has been tested and reaches a minimum of 180 degrees Fahrenheit during the rinse cycle when the dishwasher has been cycled appropriately 3 times with empty racks prior to use. The soy sauce and grape jelly have been discarded and replaced with new bottles. Current soy sauce and grape jelly is stored appropriately in the refrigerator. 2. All residents are at risk for the failure to maintain the dishwasher, scoop storage drawer, ceiling ventilation fans, ceiling pipes, and floor drains in a clean and sanitary manner to prevent the buildup of crumbs, rust, grime, an limescale, failure to ensure the refrigerator is maintained at a temperature of 41 degrees or below to prevent the potential growth of foodborne illness-causing bacteria, failure to ensure the high-temperature of 180 degrees Fahrenheit during the rinse cycle to adequately sanitize dishware, and the failure to properly store food items that have a manufacturer's label that read "refrigerate after opening."	02/20/2024

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F 812	Continued From page 40 Fahrenheit to prevent the potential growth of foodborne illness-causing bacteria. *Ensure the high-temperature dishwasher reached a minimum temperature of 180 degrees Fahrenheit during the rinse cycle to adequately sanitize dishware. *Properly store two food items that had manufacturer's labels that read "refrigerate after opening." Findings include: 1. Observation and interview on 1/7/24 from 2:11 p.m. through 2:38 p.m. in the kitchen revealed: *The reach-in refrigerator that was located to the left of the steam table had a "Refrigerator Temperature Log" taped to the door. There were nine recorded instances of temperatures above 41 degrees Fahrenheit for the month of January. *Interview with dietary manager (DM) P revealed she was aware the refrigerator had trouble maintaining its temperature. -After the previous recertification survey from 2023, they replaced the temperature gauge on that refrigerator. -They also placed at least three separate thermometers throughout that refrigerator to further monitor the temperatures. -She believed the temperature was difficult to maintain due to the constant use of that refrigerator, with staff opening the doors frequently. *There was a bottle of soy sauce sitting on a shelf at room temperature. -The manufacturer's label indicated "refrigerate after opening." -The "best by" date was 11/8/23. -There was an open date of "9-7" written on the cap. *There was a clear plastic container of grape jelly	F 812	3. The kitchen cleaning schedule has been updated to include the identified areas of concerns, excluding the ceiling pipes and vents. The cleaning of the ceiling pipes and vents have been added to the preventative maintenance plan to be completed monthly. New temperature logs to include temperature A and temperature B has been posted on each refrigerate to check daily and notify supervisor is a temperature reading is not adequate. Directions for running an empty rack through the dishwasher 3 times prior to use has been posted in the dishwash room. Regional Culinary Operations Director or designee will educate all dietary staff and the Administrator on maintaining a clean and sanitary kitchen by following the updated cleaning schedule, the new process of maintaining 2 temperature gauges in each refrigerator and notification to supervisor if temperatures are above 41 degrees, the procedure for running empty rack through 3 dishwasher cycles to ensure temperatures reach 180 degrees Fahrenheit for rinsing prior to use and when dishwasher remains idle for 15 minutes or longer, and to ensure food items are stored appropriately in the refrigerator when the label reads “refrigerate after opening”. Education will occur no later than February 20, 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.	

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F 812	Continued From page 41 sitting on the counter. The container felt room temperature when touched. -There was a can of unopened grape jelly in the storage room with the manufacturer's label indicating to "refrigerate after opening." *There was evidence of rust, limescale, and grime buildup on the inside and outside of the dishwasher. There was extensive grime buildup on the pipes below and behind the dishwasher and on the wall behind the dishwasher. *Interview at that time with dietary aide (DA) L revealed that the dishwasher was delimed at least weekly. -She indicated that she cleaned the outside of the dishwasher after every meal by using the spray bottle of an unidentified liquid, and then the stainless-steel polish. *The dishwasher temperature log had nine instances where the recorded rinse cycle temperature was below the minimum temperature of 180 degrees Fahrenheit. *There was a thick layer of dust buildup along all the ceiling pipes throughout the kitchen. The pipes were above the food preparation areas. *There was more dust buildup on the ceiling vents above the dishwasher. One of the vents was directly above the clean dish area. *The floor drains for the three-compartment sink and the dishwasher had a thick buildup of black grime. *The scoop storage drawer was scattered with dried food crumbs. Several of the scoops were still wet from the dishwasher and had bits of wet food within the crevices. Observation and interview on 1/8/24 at 9:20 a.m. with DM P in the kitchen revealed: *All the above equipment was in the same condition as described.	F 812	4. Administrator or designee will audit the kitchen 5 times per week to ensure the dishwasher, scoop storage drawer, ceiling ventilation fans, ceiling pipes, and floor drain are free of buildup of crumbs, rush, grime, limescale and dust to ensure a clean and sanitary kitchen, refrigerator temperatures are maintained at 41 degrees Fahrenheit or below to prevent foodborne illness-causing bacteria, the dishwasher rinse cycle reaches 180 degrees Fahrenheit to adequately rinse dishware, and food items are store appropriately if the manufacturer's label read "refrigerate after opening." Audits will be weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator or designee at the monthly 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 812	Continued From page 42	F 812		

*The soy sauce and jelly remained sitting out at room temperature.
*The refrigerator temperature was at 42 degrees Fahrenheit.
*DM P again explained that the internal temperature of the refrigerator went up, especially during mealtimes, when staff were frequently opening the doors.
-She said it took about an hour after mealtimes, when the doors remained closed, for the refrigerator to get back down to 41 degrees or below.
*When asked about the cleaning process for the ceiling pipes, she indicated that they were dusted weekly.
-She confirmed that the task was not on the cleaning checklists, rather she would assign it to a staff member as needed.
-She said that the pipes may not have been cleaned last week.
*When asked about the dishwasher rinse cycle temperatures, she said that sometimes they would have to run the dishwasher through a few cycles for the water to heat back up to the proper temperature.
*It was discussed that the same concerns about the refrigerator, the soy sauce, and the jelly were observed on the previous year's recertification survey, and DM P confirmed those were recurring issues.

Observation on 1/9/24 at 10:22 a.m. in the kitchen revealed:
*The inside and outside of the dishwasher had been cleaned. However, a layer of limescale and food grime buildup was still present on the top inside edges of the dishwasher doors.
*The wall behind the dishwasher had been cleaned.

F 812 Continued From page 43 F 812

*The ceiling pipes had been cleaned.
*The ceiling vents, floor drains, and scoop storage drawer remained in the same condition.
*The soy sauce and the jelly remained sitting out at room temperature.

Interview on 1/9/24 at 11:47 a.m. with DM P about the drawers, floor drains, soy sauce, and jelly revealed:
*It was her expectation that staff cleaned the drawers twice per week.
*She was not aware of the condition of the floor drains.
*She confirmed the soy sauce and jelly should have been stored in the refrigerator rather than at room temperature.

2. Review of the provider's "Dishmachine Temperature Log" for January 2024 revealed:
*On 1/1/24, the rinse temperature at breakfast was 170 degrees, and at lunch was 175 degrees.
*On 1/2/24, the rinse temperature at breakfast was 176 degrees, and at lunch was 177 degrees.
*On 1/3/24, the rinse temperature at breakfast was 177 degrees.
*On 1/4/24, the rinse temperature at breakfast was 179 degrees.
*On 1/5/24, the rinse temperature at breakfast was 176 degrees.
*On 1/6/24, the rinse temperature at breakfast was 174 degrees.
*On 1/7/24, the rinse temperature at breakfast was 176 degrees.
*The bottom of the page indicated that the high-temperature machines needed to be at or above 180 degrees Fahrenheit.

Review of the provider's undated "Recording of Dishmachine Temperatures" policy revealed:

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F 812	Continued From page 44 *"1. .....Allow dishmachine to run 10 minutes in order to bring water temperature up to proper level by sending several empty racks through the machine." *"3. Record temperatures every shift on 'Dishmachine Temperature Log.' General recommendations according to US Department of Health and Human Services:" -"High Temperature Dishmachines ..... Wash Temperature 150 degrees - 165 degrees Fahrenheit..... Rinse temperature [greater than or equal to] 180 degrees Fahrenheit." *"4. Any inaccurate temperatures must be brought to the attention of the Director of Food and Nutrition Services....immediately." *"5. Periodically the Director of Food and Nutrition Services ....should check the accuracy of the gauges by sending a thermometer or thermal strip through the dishmachine. .... Regular monitoring and maintenance is essential to maintain proper temperature." *"8. Dishmachine Temperature Log:" -".... e. Report temperatures that are less than the required levels to the Director of Food and Nutrition Services ... and immediately convert to paper service until the temperature is corrected." 3. Review of the provider's "Refrigerator Temperature Log" for January 2024 revealed: *On 1/2/24, the afternoon and evening temperatures were at 42 degrees. *On 1/3/24, the evening temperature was at 42 degrees. *On 1/4/24, the afternoon temperature was at 42 degrees, and the evening temperature was at 48 degrees. *On 1/5/24, the afternoon temperature was at 42 degrees, and the evening temperature was written as either 48 or 40 degrees.	F 812		

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F 812	Continued From page 45	F 812		

*On 1/6/24, the afternoon temperature was at 43 degrees.
*On 1/7/24, the afternoon temperature was at 42 degrees.

Review of the provider's 8/8/19 "Record of Refrigeration Temperatures" policy revealed:
*"2. Internal thermometers are to be in the warmest area of refrigerator or freezer. Record temperatures from the internal thermometers."
*"4. The refrigerator must be clean and temperatures must be 41 degrees Fahrenheit or less. Per the Food Code, a 1 [to] 2 degree variance is allowed for accuracy. Take internal temperature of some potentially hazardous foods stored in unit to determine if they are maintained at 41 degrees Fahrenheit."
*"5. Temperatures greater than these areas are to be reported to the Director of Food and Nutrition Services immediately."
*"6. Note on the temperature forms the plan of action taken when temperatures are not in acceptable range."

4. Review of the provider's cleaning checklists from October to December 2023 revealed:
*There were no tasks to remind staff to clean the drawers, the ceiling pipes, the ceiling vents, or the floor drains.
*All the tasks had been initialed. None of the tasks were missed.

Review of the provider's undated "Floors/Floor Mats/Baseboards" procedure revealed:
*"18. Assure drains are scrubbed and free of debris."

Review of the provider's undated "Shelves and Other Surfaces" procedure revealed:

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F 812	Continued From page 46 *"3. Keep fans clean and free of dust particles." *"4. Clean floor drains and keep free of debris." Review of the provider's undated "Walls and Ceilings" procedure revealed: *"Sanitation:" -"1. Walls and ceilings must be free of chipped and/or peeling paint and there should be no holes in the walls or ceiling......Ceiling sprinklers must be free of dust and debris." -"2. Walls and ceilings must be washed thoroughly at least twice a year. Heavily soiled surfaces must be cleaned more frequently and as required. It is important to repair peeling paint areas as soon as they appear." -"5. Vents must be free of [chips] and/or peeling paint and they must be clean and free of debris."	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy and procedure and job description the provider failed to ensure the facility was operated and administered by administrator A, in a manner that ensured the safety and overall well-being of all 52 residents in the facility. Findings include: 1. Refer to F812, finding 1 2. Observation on 1/7/24 at 1:52 p.m. revealed	F 835	1. Immediate corrections have been made for all residents affected with a deficient practice. 2. All residents are at risk resulting from failing to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being of all residents. The Vice President of Operations (VPO) or designee reviewed the Administrator job description with the Administrator. 3. The VPO, Regional Nurse Consultant (RNC) or designee will meet with the Administrator and DON every week, either in person or by phone, to review each week's progress and offer support and training as needed. 4. VPO, RNC or designee will complete a visit report for each visit. Visits will be weekly for 4 weeks and then monthly for 2 months. VPO, RNC or Designee will discuss results through monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits	02/20/2024

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F 835	Continued From page 47	F 835		

the posted nursing staffing information was not consistently posted.

3. Interview on 1/9/24 at 3:52 p.m. with administrator A revealed:
*He stated if he knew Minimum Data Set (MDS) coordinator D was gone, he would have assigned another staff member to have completed the posted nurse's staffing information.
*He had been attending quality assurance and performance improvement (QAPI) monthly.
*When staff called in to say they could not work, the nurses attempted to find a replacement. If they had not been able to, then the nurse management worked the floor.
*He was not aware the kitchen refrigerator temperature had been getting too high and the dishwasher temperature had not been getting high enough.
-He stated he completed audits in the kitchen from January 2023 through September 2023 for cleanliness, hand hygiene, food storage and floors being swept, mopped and cleaned.
-He stated he had done weekly walkthroughs in the kitchen and had looked at the refrigerators and dishwashers temperature check-off sheets, but had not noticed they were not at the correct temperatures.
*He was aware dietary manager P was not ServSafe certified.
-He knew the dietary department had only one cook that was Servsafe certified.
-He agreed more dietary staff needed to be Servsafe certified.

4. Review of the 1/13/23 recertification survey revealed the following tags were recited on the current recertification survey: F692, F812, and F865.

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F 835	Continued From page 48 Review of 2023 Plan of Corrections of F692 revealed: *"Any resident who triggered a significant weight loss were reviewed by registered dietician (RD) and director of nursing (DON), and all families and providers were notified of weight change and current interventions." *"3. The DON or designee will evaluate weight loss weekly and report weight loss to families and providers." Review of 2023 Plan of Corrections of F812 revealed: *"2. All residents at risk if food is not stored, prepared, or distributed with professional standards. All residents are at risk if foods handlers do not use proper hand hygiene prior to preparing food." *"4. The administrator or designee will audit five meal services for observation of hand hygiene prior to serving weekly for three months. The administration or designee will audit cleanliness of kitchen, including floors, storage of food and equipment, and completion of cleaning checklist three times per week for three months. Results of the audits will be discussed at monthly resident council for the next three months by Administrator or designee and at the monthly QAPI meeting with IDT present for continuation/discontinuation/revision of audit based on audit findings." Review of 2023 Plan of Corrections of F865 revealed: *"All residents are at risk. Audits will be performed to ascertain compliance with facility policies and regulations and will be discussed at monthly QAPI as needed."	F 835		

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F 835	Continued From page 49 Review of updated 12/1/2019 Administrator job description revealed: *"1. Develops and implements facility polices and procedures that comply with Federal, State and local regulations." *"6. Participates in Federal, State and Local agency annual surveys." *"7. Review with appropriate department heads any deficiencies noted by government agencies during inspections." *"8. Develop and implement a plan of correction with the assistance of appropriate department head for any deficiency found by a government agency and forward the plan to appropriate governing board." *"25. Establish overall QAPI objectives for the organization and assign responsibility for their fulfillment." *"26. Accept responsibility and oversee development of QAPI plan, including policies for ensuring that QAPI activities are given high priority in the overall management of facility operations." *"29. Ensure QAPI in the organization includes a mechanism for obtaining resident and family input to consider as potential areas for improvement." *"30. Create and maintain a consistent process to stay informed of all QAPI efforts underway including their progress and achievements." Refer to F692, F732, F812, F865.	F 835		
F 849 SS=F	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following:	F 849	1. No immediate corrective action could be taken for the failure to ensure current collaborative communication was documented and accessible between the provider and hospice agency for residents 24, 33, and 50.	02/20/2024

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F 849	Continued From page 50 (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following:	F 849	2. All residents receiving hospice services are risk for failure to ensure there is current collaborative communication documented and accessible between the provider and the hospice agency. A full house audit of all residents receiving hospice services will be completed no later than February 20, 2024, to ensure there is current collaborative communication documented and accessible between the provider and the hospice agency. 3. The Administrator and the DON met with the hospice agency leadership on January 22, 2024, to discuss concerns and developed a plan to ensure current collaborative communication is documented and accessible to the facility staff and the hospice agency. Hospice leadership provided an extended calendar which includes the cares their CNA's will provide for the following week. A communication notebook was placed at each hospice resident's bedside table to allow for better communication between the hospice agency and facility staff. Hospice agency will keep a binder at the facility nurse's station and update it weekly to ensure better communication between facility staff and the hospice agency. The DON or designee with educate the IDT, to include MDS coordinator D, and all nurses on the Hospice Services policy to ensure there is collaborative communication documented and accessible between the provider and the hospice agency. Education will occur no later than February 20, 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.	

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F 849	Continued From page 51 (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F 849	4. The DON or designee will conduct an audit of all residents receiving hospice services to ensure there is current collaborative communication documented and accessible between the provider and the hospice agency. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly 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 849	Continued From page 52 (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's	F 849		

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attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and review of the Hospice and Nursing Facility Services Agreement, the provider failed to ensure there

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F 849	Continued From page 54 was current collaborative communication documented and accessible between the provider and hospice agency for three of three sampled residents (24, 33, and 50) receiving hospice services. Findings include: 1. Review of resident 24's electronic medical record (EMR) revealed: *Hospice services had been initiated on 11/14/23. *There was no Hospice tab or any hospice agency documentation found in the resident's paper chart. 2. Review of resident 33's EMR revealed: *Hospice services were initiated on 10/14/22. *Behind the Hospice tab in that resident's paper chart was the hospice agency's Hospice Plan of Care/Care Plan Summary dated 7/27/23 through 9/24/23. 3. Review of resident 50's EMR revealed: *Hospice services were initiated on 8/23/23. *Behind the Hospice tab in that resident's paper chart was the hospice agency's Care Plan Summary dated 8/23/23 through 11/23/23. Interview on 1/8/24 at 9:15 a.m. with an unidentified hospice agency masseuse regarding hospice collaboration revealed: *She documented her hospice visits with the hospice agency's computerized documentation program that was not accessible to the facility staff. -No documentation was completed in either the resident's EMR or paper chart by the hospice agency. *There was no "hand-off communication" process between the hospice agency and a designated nursing home staff person before or following her	F 849		

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F 849	Continued From page 55 hospice visits at the nursing home. Interview on 1/8/24 at 2:42 p.m. with licensed practical nurse (LPN) E regarding hospice collaboration revealed: *The hospice nurse usually spoke with the hospice resident's floor nurse before and following a hospice visit to discuss any pertinent resident-related concerns. *If LPN E had been away from work for several days then returned she would have only known if there were hospice-related concerns if the previous days nursing staff had documented something in a nurse's progress note. *"We don't know when they [hospice staff] plan to visit the [hospice] resident." -Staff, residents, and family had no schedule to refer to for planned hospice staff visits. Interview on 1/8/24 at 4:15 p.m. with Minimum Data Set (MDS) coordinator/registered nurse (RN) D regarding hospice collaboration: *The hospice agency completed their hospice documentation for residents in the facility that were on hospice using their own computer system which the facility had no access to. -MDS coordinator/RN D worked with the hospice agency to ensure resident hospice documentation was regularly sent to the facility. *Hospice-related documentation received from the hospice agency was reviewed by MDS coordinator/RN D for any pertinent findings. -She had November 2023 and December 2023 hospice agency documentation in a file on her desk that she had not yet reviewed. -After it was reviewed she forwarded it to central supply clerk X for scanning into the resident's EMR and filing in the resident's paper chart.	F 849		

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F 849	Continued From page 56 Interview on 1/8/24 at 4:30 p.m. with central supply clerk X revealed: *She notified MDS coordinator/RN D about not having received current hospice documentation for residents 24, 33, and 55. -MDS coordinator/RN D was supposed to have followed-up with the hospice agency. Review of the Hospice and Nursing Facility Services Agreement revealed: *3.1.10 Communication: -"(a) Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. After every communication between Hospice and Facility, each Party shall document the communication in its respective clinical records to ensure that the needs of Hospice Patients are met twenty four (24) hours per day."	F 849		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and	F 865	1. See previous deficiencies' plan of corrections for immediate actions and educations that pertain to identified deficiencies. No other immediate actions could be taken. 2. All residents are at risk. Audits will be performed to ascertain compliance with facility policies and regulations and will be discussed at monthly QAPI as needed. 3. The IDT, including the Administrator, will be educated by VPO or designee on the elements of an effective QAPI program. This education will be completed no later than February 20, 2024. 4. VPO or designee will attend QAPI monthly for 3 months to review the process and provide feedback to the Administrator and IDT on areas of opportunity. Need for continuation will be re-evaluated at the time.	02/20/2024

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F 865	Continued From page 57 documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.	F 865		

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§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _______ B. WING _______	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 865	Continued From page 59	F 865		

the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on interview, policy review, and quality assurance and performance improvement (QAPI) plan, the provider failed to ensure performance improvement projects (PIP) had been thoroughly implemented, monitored, and resolved with an effective QAPI process. Findings include:

1. Interview on 1/9/24 at 3:52 p.m. with administrator A revealed:
*The provider held QAPI meetings monthly.
*They used information from each department audits, grievances (from family or staff), and resident council minutes.
*They ranked identified issues and then prioritized the issues from that listing.
-They had falls and bathing for their PIPs.
*When staff were calling in, the nurses would attempt to find a replacement. If they were not able to find a replacement, then the nurse management would work the floor.
*He was unaware the kitchen refrigerator temperature had been getting too high and the dishwasher temperature had not been getting high enough.
-He stated he completed audits in the kitchen from January 2023 through September 2023 for cleanliness, hand hygiene, food storage and floors being swept, mopped and cleaned.
-He stated he had done weekly walkthroughs in the kitchen and looked at the refrigerators and

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	435047	A. BUILDING ______ B. WING ______	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

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F 865	Continued From page 60 dishwasher temperature check-off sheets, but he had not noticed they were not at the correct temperatures. *He was aware dietary manager P was not ServSafe certified. -He knew the dietary department had only one cook that was Servsafe certified. -He agreed more dietary staff needed to be Servsafe certified. *He stated if he knew Minimum Data Set (MDS) and registered nurse (RN) D had been gone, he would have assigned another staff member to complete the posted nurse's staffing information. 2. The QAPI committee members verbally listed by administrator A were: -The medical director. -Administrator A. -Director of nursing B. -Assistant director of nursing C. -Infection control nurse F. -Social service designee H. -Business office manager O. -Human resource director Q. -Dietary manager P. -MDS coordinator D . -Activities director G. -There were no direct care staff. 3. Review of the provider's revised 7/30/20 QAPI policy revealed: *"1)This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigating, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities." *"2) The QAPI must address all systems of care	F 865		

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	435047	A. BUILDING ______ B. WING ______	C 01/09/2024

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F 865	Continued From page 61 and management practices and include clinical care, quality of life, and resident choice. It should utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents." *"3) The members of the QAPI committee must meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary." *"They must also develop and implement appropriate plans of action to correct identified quality deficiencies." Review of the provider's 2021 Quality Assurance and Performance (QAPI) Plan revealed: *"When the need is identified, we will implement corrective action plans or performance improvement projects to improve processes, systems, outcomes, and satisfaction." *"The goal of this committee is to aim for the highest level of safety, excellence in clinical interventions, resident and family satisfaction and management practices. Our committee will prioritize topics for PIPs based upon current needs of the resident and our organization. This team will follow steps and processes that are needed to achieve quality improvement and respond in a timely manner to assure momentum is maintained." *"Priority will be given to areas we define as high risk to residents and staff, high prevalence or high-volume areas, and areas that are problem prone."	F 865		

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

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	435047	A. BUILDING ______ B. WING ______	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

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F 865	Continued From page 62 *"The facility will keep staff updated on new QAPI initiative and PIPs that are being worked on and ask for staff involvement where appropriate to solicit ideas and feedback." *"Avantara Pierre will use data at every QAPI Committee to ensure performance measures are meeting QAPI goals." -That data was to come from: "input from caregivers, residents, families, and others, adverse events, quality measures/performance indicators, Survey and Living Center Annual Performance Assessment (LCPA) findings, complaints, and consultant reports." Refer to F732 and F812	F 865		

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

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	435047	A. BUILDING ______ B. WING ______	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET PIERRE, SD 57501**

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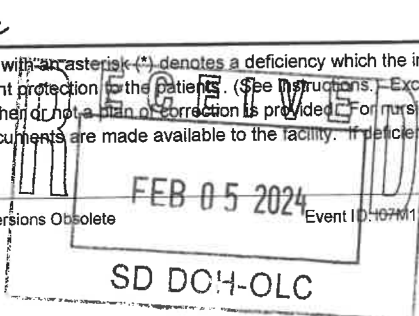
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 1/7/24 through 1/9/24. Avantara Pierre was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chase Watson
TITLE: Administrator
(X6) DATE: 02/01/2024

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.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING 01 - **MAIN BUILDING 01** B. WING ______	**01/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

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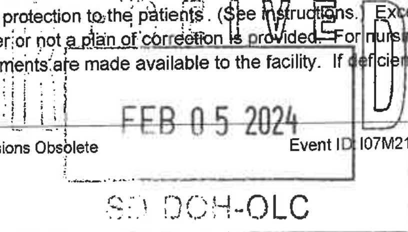
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/8/24. Avantara Pierre was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chase Watson	Administrator	02/01/2024

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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FORM APPROVED

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
	10663	A. BUILDING: ______ B. WING ______	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 E PARK** **PIERRE, SD 57501**

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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 1/7/24 through 1/9/24. Avantara Pierre was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/7/24 through 1/9/24. Avantara Pierre was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chase Watson	Administrator	02/01/2024