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 04/02/2025

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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 3/30/25 through 4/2/25. Avantara Pierre was found not in compliance with the following requirements: F554, F584, F625, F656, F686, F689, F847 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/30/25 through 4/2/25. The area surveyed was resident neglect related to a resident who was transferred to the emergency room without being provided personal hygeine after being incontinent of loose stool. Avantara Pierre was found not in compliance with the following requirement: F600.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (24) who self-administered medications was able to safely self-administer those medications and had a physician's order for self-administration of medications per the provider's policy. Findings include: 1. Observation and interview on 3/30/25 at 5:10 p.m. in resident 24's room revealed:	F 554	1. A new medication self-administration evaluation was completed on April 22, 2025 for resident 24 indicating that he can safely self-administer his neti pot and nebulizer treatments once set up by nurse. A physician's order was received on April 22, 2025 that he may self-administer his neti pot and nebulizer treatments once set up by nurse. 2. All residents are at risk for not being assessed to ensure they are able to self-administer medications safely and that a physician's order has been obtained for self-administration of medications. A full house audit of all residents will be completed to determine if resident expresses the desire to self-administer medications. If resident desires to self-administer medications a new medication self-administration evaluation will be completed to determine if resident is able to safely self-administer their medications, and a physician's order has been obtained that resident may self-administer medications.	5/1/2025

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

Chase Watson | Administrator | 4/28/2025

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

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F 554	Continued From page 1 *The resident was sitting in his recliner chair, administering a nebulizer (a liquid medication that turns into mist and is inhaled through a mask or mouthpiece via a small machine) treatment. *There was a medication cup that contained one medication tablet on the resident's bedside table. -The resident indicated the medication was "Tums" (an antacid medication). *A bottle of nasal spray (Fluticasone Propionate) was on the resident's bedside table. *He stated that he was able to administer medications and the nebulizer treatment independently in his room, just as he would at home. 2. Review of resident 24's electronicmedical record (EMR) revealed: *He was admitted on 9/11/24. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated he was cognitively intact. *A self-administration evaluation was completed on 1/27/25 and indicated he was not able to self-administer medications. *There was no physician order for him to self-administer his medications. 3. Interview on 4/1/25 at 1:57 p.m. with director of nursing (DON) B revealed: *She confirmed the 1/27/25 self-administration evaluation indicated that resident 24 was not able to self-administer his medications. *She confirmed there was no physician order for resident 24 to self-administer his medications. 4. Observation on 4/1/25 at 4:20 p.m. of resident 24 in his room revealed: *The resident was sitting in his chair while he administered a nebulizer treatment.	F 554	3. The Director of Nursing (DON) or designee will educate all licensed nurses, to include licensed practical nurse (LPN Q), on the Self-Administration of Medications policy to ensure a medication self-administration evaluation has been completed, and if deemed able to safely self-administer medication, then to ensure a physician's order is obtained that resident may self-administer medications. Education will be completed no later than May 1, 2025 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 complete an audit of 5 residents to ensure a medication self-administration evaluation has been completed if a resident expresses a desire to self-administer to determine if resident can safely self-administer medications. If resident is deemed safe to self-administer medications, a physician's order has been obtained to allow resident to self-administer medications. Additionally, the DON or designee will complete an audit of 5 licensed nurses, to include LPN Q, during medication pass to ensure only residents that have been evaluated to be safe to self-administer medications and have a physician's order to self-administer medications are allowed to self-administer medication. Audits will be completed 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 Assurance Performance Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 554	Continued From page 2 *The bottle of Fluticasone Propionate nasal spray was on his bedside table. *No staff was observing the administration of the nebulizer treatment. 5. Interview on 4/2/25 at 10:30 a.m. with licensed practical nurse (LPN) Q revealed: *She would stand outside resident 24's room while he took the nebulizer treatment. *She could not confirm if resident 24 had an assessment to self-administer medications. *She would not leave medications in resident rooms. *She would verify that all the residents had taken their medications. 6. Interview on 4/2/25 at 1:07 p.m. with resident 24 revealed he stated: *The nurses left the above medications on his bedside table for him to take. *The nurses never stayed in the room during his nebulizer treatments. Review of the provider's 11/19/24 Self-Administration of Medications policy revealed: *"Each resident has a right to self-administer medications should they desire, unless this practice is determined unsafe." *"If the resident has expressed a desire to self-administer, the interdisciplinary team will complete an evaluation of the resident's cognitive, physical, and visual ability to carry out this responsibility." *"The facility may require that drugs be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make a determination on resident's ability to complete the task."	F 554		

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F 554	Continued From page 3 *"Nurse is to get an order from the clinician for self-administration of medications."	F 554		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584	1. An indoor window film insulation kit has been installed over the windows in the rooms of residents 27 and 304 as an immediate temporary corrective action. Resident 24 refused the window film insulation kit, and his roommate agreed as they prefer to have their window open for fresh air. The facility has purchased windows for replacement in the rooms of residents 24, 27, and 304. The windows will be installed once received. 2. All residents are at risk for their room being too cold and uncomfortable due to inadequate room temperatures. A quote has been obtained by the facility for windows that are requiring replacement in the facility. 3. The Administrator will educate all staff on the Homelike Environment policy to ensure that resident rooms are being maintained at an adequate and comfortable temperature. Education will be completed no later than May 1, 2025 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 Administrator or designee will conduct an audit to interview 5 residents to ensure their room is being maintained at a comfortable temperature as well as obtaining the temperature of that room. The audit will include one of residents 24, 27, or 304 each week. Audits will be 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.	5/1/2025

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F 584	Continued From page 4	F 584		

levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, testing, and policy review, the provider failed to ensure adequate temperatures for three of three sampled residents (24, 27, and 304) who expressed their rooms were cold and uncomfortable.
Findings include:

1. Observation and interview on 3/30/25 at 4:40 p.m. in resident 27's room revealed:
*The temperature of the room felt cold in comparison to other areas within the facility.
*The resident was in bed and covered with blankets.
*The window shade was down with a blanket along the bottom edge of the window.
*The resident stated:
-She would get into her bed under the blankets to stay warm.
-The room was cold and she had no control over the temperature in her room.
-The maintenance man would check the boiler when she reported her room was cold, but her room temperature would remain cold and uncomfortable for her.

2. Review of resident 27's electronic medical record (EMR) revealed:
*She was admitted on 9/23/21.
*She had a Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated

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F 584	Continued From page 5 she was cognitively intact. 3. Observation and interview on 3/30/25 at 5:10 p.m. in resident 24's room revealed: *The temperature of the room felt cold in comparison to other areas within the facility. *The resident was wearing a lined shirt/jacket and was sitting in his recliner chair. *The window shade was down and two pillows were along the bottom edge of the window. *The resident stated the room was cold, and he walked the hall multiple times daily to warm up. *The resident used extra blankets at night to stay warm. 4. Observation and interview on 3/31/25 at 4:00 p.m. with resident 24 in the west hallway revealed: *The resident was walking up and down the hall with his walker. *He stated he needed to be out of his room and moving to warm up because his room was cold, and he was "freezing". 5. Review of resident 24's EMR revealed: *He was admitted on 9/11/24. *He had a BIMS assessment score of 15, which indicated he was cognitively intact. 6. Observation and interview on 3/31/25 at 9:00 a.m. in resident 304's room revealed: *The temperature of the room felt cold in comparison to other areas within the facility. *The resident returned from therapy and entered her room and stated, "The room is a bit chilly." *The window shade was up and a blanket was along the bottom edge of the window. *The resident stated the room would get cold if the door was shut.	F 584		

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F 584	Continued From page 6 7. Review of resident 304's EMR revealed: *She was admitted on 3/17/25. *She had a BIMS assessment score of 12, which indicated she had moderate cognitive impairment. 8. Interview on 4/1/25 at 9:57 a.m. with maintenance director H revealed: *The resident room temperatures should range be between 70 and 80 degrees Fahrenheit (F). *The facility used boiler heat, which could only be adjusted for some areas of the building. -He stated it was difficult to maintain temperatures for residents who were hot or cold. *Resident room temperatures were checked and documented five times weekly. -He would check three to four temperatures in resident rooms and then document the average of those temperatures. *The boilers were checked when the resident room temperatures were out of range. *He stated the resident rooms' windows leaked allowing outside air into the room and the windows should be replaced. *Thermostats were located throughout the building and were locked so staff and resident could not adjust them. -No thermostats were located within the resident rooms. *Temperature settings were controlled by the maintenance department staff. -The thermostats were set between 70 and 72 degrees F. *He stated a local vendor would complete a check on the facility boilers as requested. 9. Temperature testing on 4/1/25 at 10:07 a.m. with maintenance director H in resident 24's room	F 584		

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revealed:
*The north wall temperature next to the resident's bed was 65.3 degrees F.
*The west wall next to the resident's recliner chair was 68.4 degrees F.
*The south wall next to his roommate's bed was 69.1 degrees F.

10. Interview on 4/1/25 at 1:33 p.m. with the assistant director of nursing (ADON) C revealed:
*The maintenance director controlled and adjusted the buildings' thermostats for the temperatures of the rooms.
*She did not think anyone else touched the thermostats or adjusted the temperatures.

11. Interview on 4/2/25 at 9:06 a.m. with activity aide O revealed:
*She had never touched a thermostat at the facility to adjust a room temperature.
*She was unsure if the residents' rooms had thermostats.

12. Interview on 4/2/25 at 9:09 a.m. with CNAP revealed:
*She confirmed there were no thermostats in residents' rooms to control and maintain comfortable temperatures according to their preferences.
*The maintenance director controlled and adjusted the thermostats for temperature control throughout the building.

13. Interview on 4/2/25 at 9:23 a.m. with administrator A revealed:
*The facility areas and residents' room temperatures were monitored weekly and documented by the maintenance director.
*A grievance was presented at the 2/18/25

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F 584	Continued From page 8 resident council meeting regarding cold resident rooms. *There was a plan to replace the facility's windows. *The expectation was for residents' rooms to be at adequate temperature settings to maintain a comfortable level. *The residents' room temperature should be maintained between 71 and 81 degrees F. *He confirmed that residents' room temperatures below 70 degrees F was not within the required temperature range. Review of the resident council grievance form dated 2/18/25 revealed the residents had complained of being too cold and that the heat needed to be turned up. Review of the investigation and follow-up responses dated 2/19/25 on the above grievance form revealed: *Maintenance was educated on air temperature parameters and steps for notification if the air temperatures were out of range. *The required temperature range should be between 71 and 81 degrees F. *The thermostat was to be adjusted ifthe temperatures were out of range. *The corporate maintenance consultant and the administrator were to be notified if the appropriate temperatures were not reached. *If necessary, maintenance was to follow up with the vendor as soon as possible. Review of the providers 9/30/24 Homelike Environment policy revealed: *"Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to	F 584		

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F 584	Continued From page 9 the extent possible." *"Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences." *"The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:" -"Comfortable temperatures."	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, and policy review, the provider failed to protect the resident's right to be free from neglect for one on one sampled resident (206) who expressed he felt bad that he had been sent to the emergency room (ER) by registered nurse (RN) (N) without being provided personal hygiene	F 600	1.DON provided immediate verbal education via phone to Registered Nurse (RN) N on resident dignity and neglect upon discovery at the time of the incident on March 15, 2025. RN N was suspended pending results of an investigation. A skin assessment was performed on resident 206 on March 15, 2025 to rule out impaired skin integrity with no new skin concerns identified. Immediate education was initiated on March 15, 2025 to all staff on ensuring residents' dignity is maintained, as well as on abuse and neglect. Upon completion of the investigation, RN N was issued a disciplinary write-up and was educated on the Resident Dignity and Privacy policy and the Abuse and Neglect policy prior to being reinstated on March 19, 2025. 2. All residents are at risk for failure to protect their resident's right to be free from neglect.	5/1/2025

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F 600	Continued From page 10 after he had been incontinent of loose stool. Findings include: 1. Review of the provider's 3/15/25 SD DOH FRI regarding resident 206 revealed: *He was admitted to facility on 3/13/25. *His Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated he was cognitively intact. *On 3/14/25 he was transported to a local ER for evaluation by ambulance. -A paramedic observed he had loose stool leaking out of the side of his brief, and reported that to RN N. -RN N did not offer to clean or provide personal hygiene to the resident at the time of transport. *The paramedic reported that information to director of nursing (DON) B when he called her about the incident and added: -The ambulance team would transport the resident. -The hospital may not be happy about the condition of resident 206 upon arrival to the ER. *DON B gave immediate verbal education to RN N via phone on resident dignity and neglect. *RN N was suspended pending the provider's investigation of the incident. *Resident 206 returned to provider facility on 3/15/25. *A skin assessment was completed on 3/15/25 on resident 206, with no new skin concerns noted. *All staff education had been initiated on ensuring resident dignity was maintained, as well as abuse and neglect. *The resident's primary care provider (PCP) was notified of the incident. *The local police department was notified of the incident.	F 600	3. Administrator, DON, and the interdisciplinary team (IDT) in collaboration with the medical director reviewed the Abuse and Neglect policy to ensure all residents are free from neglect and receive proper care and services required related to their personal hygiene and incontinence needs. The DON or designee will educate all direct care staff responsible for providing resident care, to include RN N, regarding their role and responsibilities to ensure resident care and services for those areas. Additionally, the DON or designee will educate all staff on the Abuse and Neglect policy including the definition of neglect. Education will be completed no later than May 1, 2025 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 complete an audit of 5 residents to ensure their personal hygiene and incontinence care needs have been provided timely. This audit will include an interview with those 5 residents to ensure they feel their care needs have been met. Audits will be completed 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 600	Continued From page 11 2. Interview on 4/2/25 at 9:00 a.m. with RN N revealed: *Resident 206 had been having loose stools on 3/14/25 in the evening and was not taking fluids. *He was on a strict fluid restriction. *His blood sugar was 126. *She had orders to give him insulin. *She had called the on-call provider, who gave an order to send the resident to the ER for evaluation of his loose stools and low fluid intake. *She had called the hospital and gave them a verbal report regarding the resident. *At 9:30 p.m. on 3/14/25 staff had completed a total bed change on the resident following an incontinent episode. *When the paramedic arrived at the facility, the resident had again been incontinent of loose stool. *She had asked the paramedic if he wanted the facility staff to clean up the resident. *The paramedic had said he did not care but the hospital staff would not like it. *They did not clean the resident up and the resident was transferred to the ER. *The resident returned to facility on 3/15/25. *She stated she did not want to make the paramedics wait that evening. *She said she felt terrible that resident 206 went to the ER in that condition and the hospital staff made him feel bad about it. *She agreed that situation could have been prevented by ensuring he was provided with personal hygiene and was clean before he was sent to the ER that evening. 3. Interview on 4/2/25 at 9:30 a.m. with resident 206 revealed: *He stated the hospital staff were upset that he was incontinent of bowel when he went to the ER	F 600		

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F 600	Continued From page 12 on 3/14/25. *He felt bad because the hospital staff was upset . *They cleaned him up. *His bowels had improved since then. *He felt staff had time to change him before he went to the hospital that evening. *He had heard the paramedic tell RN N he was incontinent of bowel. *He did not remember being updated on the facility's investigation of the incident. 4. Interview on 4/2/25 at 10:25 a.m. with administrator A revealed: *He and DON B completed the investigation regarding the above incident involving resident 206 on 3/14/25. *On 3/15/25 a skin assessment was completed on resident 206, with no new areas of concern. *They had interviewed other staff working that evening as part of their investigation. *They had notified the local police of incident with resident 206. *They had notified resident 206 PCP of the above incident. *RN N had received disciplinary action and was allowed to return to duty after completion of that. *Resident 206's care plan was updated with the following intervention: -"He has frequent loose stools related to the use of lactulose for treatment of hepatic encephalopathy. He will require assistance with toileting and personal hygiene as needed initiated." on 3/19/25. *Education was provided to all staff regarding the provider's Abuse and Neglect Policy and the Dignity Policy. *No audits or monitoring related to the above incident had been completed following the incident or the completion of the investigation.	F 600		

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F 600	Continued From page 13 Review of the provider's 2/20/24 revised Abuse and Neglect Policy revealed: *"It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (&) federal components of prevention and investigations." -"Mental abuse includes, but is not limited to humiliation, harassment, threat of bodily harm, punishment, isolation (involuntary, imposed seclusion) or deprivation to provoke fear of shame." -"Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm or pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service." Review of the provider's 11/19/24 revised Resident Dignity and Privacy Policy revealed: *"It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as , care for each resident in a manner and in an environment, that maintains resident privacy." -"6. Groom and dress residents according to resident preference. Clothing should be changed when soiled. Document any resident refusals." -"10. Each resident will be provided equal access to quality care regardless of diagnosis, severity of	F 600		

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F 600	Continued From page 14 condition or payment source."	F 600		
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 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 one of five sampled residents (28) had received a bed hold notice upon her transfer out of the facility to the	F 625	1. No immediate corrective action could be taken for the failure to ensure a Bed Hold Notice form was issued to resident 28 prior to her transfer to the hospital. 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 Social Services Designee and all licensed nurses on the Discharge and Transfer of Residents/Bed Hold Policy to ensure a Bed Hold Notice form is issued to a resident prior to transfer to the hospital. In addition, the facility will utilize 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 Social Services Designee on the tracking form and where to locate it. Education will occur no later than May 1, 2025. 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 for 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 or audits based on audit findings.	5/1/2025

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F 625	Continued From page 15 emergency room (ER). Findings include: 1. Review of resident 28's electronicmedical record (EMR) revealed: *She was transferred to the emergency room for evaluation on 11/18/24. *Her emergency contact had been notified 11/18/24 of the need for an emergency room evaluation. *No documentation indicated she had received the bed hold policy information. *She was readmitted on 11/22/24. *A written notification of the bed hold was signed by the resident and her representative on 11/27/24. 2. Interview on 4/2/25 at 10:15 a.m. with administrator A regarding the bed hold for residents that required to be transferred to the ER or hospital revealed: *He confirmed resident 28 was transferred to the ER on 11/18/24. *The social services director was to follow up with the resident or resident representative for the bed hold as needed. *It was his expectation residents who had been sent to the emergency room or required hospitalization should have received a bed hold notice before or at the time of the transfer. *He agreed there was no documentation regarding the bed hold notice for resident 28 until 11/27/24 which was five days after she had returned from her hospitalization. *The social services director was unavailable for interview during the survey. 3. Review of the provider's 2/10/24 revised Discharge and Transfer of Residents/Bed Hold Policy revealed:	F 625		

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F 625	Continued From page 16 *"To ensure a safe transition is planned for any resident with a discharge to another setting. To ensure adequate care is given to any resident with a change in condition." *"The notice of Transfer/Discharge form and bed hold policy will be given to the resident or resident representative prior to the discharge or transfer."	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656	1.No immediate corrective action could be taken for the failure to provide the interventions of the floor mat and call light being within her reach for resident 3. Resident 205's care plan has been updated with appropriate interventions to prevent the development of new pressure ulcers. Resident 206's positioning alarm was discontinued on April 16, 2025. Resident 34 discharged home from the facility on April 15, 2025. 2. All residents are at risk for their care plans not reflecting their current needs and interventions not being provided to meet their care needs. A full house audit of all residents will be completed to determine risk for pressure ulcers and their care plans will be reviewed and/or revised to ensure appropriate interventions are care planned and implemented to assist in prevention of the development of new pressure ulcers. A review of all residents receiving lymphedema wraps by physical therapy will be completed to ensure their care plans reflect the intervention of lymphedema wraps.	5/1/2025

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F 656	Continued From page 17 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans reflected the residents' current needs and/or to provide interventions as directed on the care plans for four of twenty sampled residents (3, 34, 205, and 206) as follows: *Interventions were not provided as directed on the care plan for resident 3 who required a fall mat and a call light within her reach. *The care plan did not include interventions to prevent the development of a pressure ulcer for resident 205. *Interventions were not provided as directed on the care plan for resident 206 who required the use of a positioning alarm. *The care plan did not include interventions for lymphedema (condition causing swelling in the arms or legs) wraps for resident 34. Findings include:	F 656	3. DON or designee will educate the IDT and all direct care staff on the Care Plans policy to ensure residents' care plans reflect their current needs and appropriate interventions are being provided to residents. The DON or designee will educate all certified nursing assistants (CNA), to include CNAs F and K, on how to access the residents' Kardex to ensure interventions are being provided to meet the residents' care needs. Education will be completed no later than May 1, 2025 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. DON or designee will audit 5 resident care plans to ensure their care plans reflect their current needs and appropriate interventions are being provided by direct care staff to ensure floor mats are in place if indicated, call lights are within reach of the residents, personal alarms are in place if indicated, interventions are in place to prevent the development of pressure ulcers if resident is at high risk, and lymphedema wrap treatments by physical therapy are care planned. Audits will be completed 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 656	Continued From page 18 1. Observations on 3/30/25 at 3:05 p.m., 4:44 p.m., 5:06 p.m. and 5:13 p.m. of resident 3 revealed: *She was in her bed which was in a low position and against the wall. *The privacy curtain was tucked between the bed and the wall near the foot of her bed. *A blue fall mat was folded in half and propped up against her bedside table. *The call light was on a bedside table behind the fall mat and not within her reach. Observation on 3/30/25 at 5:48 p.m. with resident 3 revealed: *She was in her bed which was in a low position and against the wall. *A blue fall mat was folded in half and on the floor near her bed in a position that appeared as if it had fallen over. *The call light was on the bedside table and not within her reach. Review of resident 3's electronic medical record (EMR) revealed: *She had been admitted on 8/30/23. *Her Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated she was severely cognitively impaired. *Her diagnoses included a fracture of the right femur (thigh bone) and dementia. *Her 3/26/25 Fall Risk Evaluation indicated she had a low risk for falling. *Her care plan indicated: -She was "At risk for falls related to [the] history of falls, right hip fracture with no right hip joint, dementia, anemia and arthritis." -"Please make sure that my call light is within my reach and encourage me to use it to call for assistance."	F 656		

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F 656	Continued From page 19 -"Bed to be in low position and floor mat is placed next to the bed." Interview and record review on 4/02/25 at 8:45 a.m. with director of nursing (DON) B regarding resident 3 revealed: *She confirmed resident 3's 3/26/25 Fall Risk Evaluation indicated "Low Risk." *Resident 3 had fallen on 1/2/25 and was at risk for falls. She thought the fall mat intervention on her care plan was still needed and appropriate. *She expected that resident 3's care-planned interventions of the fall mat and ensuring resident 3's call light was within her reach would have been followed. 2. Observation and interview on 3/31/25 at 8:38 a.m. with resident 205 revealed: *He was seated in his wheelchair and wore padded pressure-reducing boots on both of his feet. *He said he had been at the facility for about two weeks and did not know why he needed to wear those boots. Observation and interview on 4/1/25 at 7:59 a.m. with resident 205 and certified nursing assistant (CNA) R in resident 205's room revealed: *CNA R stated that resident 205 had been at the facility for about two weeks. *Resident 205 wore a "Tubi Grip" (compression stocking) on his right leg and blue pressure-reducing boots on both feet due to a pressure ulcer on his right heel. *CNA R stated that information on how staff were to care for each resident was located in the residents' care plans in the EMR. Observation on 4/2/25 at 7:43 a.m. with resident	F 656		

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F 656	Continued From page 20 205 revealed: *He was lying in bed on his back with blue boots on both feet. *His bed did not have an air mattress on it. Review of resident 205's EMR revealed: *He had been admitted on 3/17/25 from another long-term care facility. *A 3/13/25 physician's order, "Transfer to [provider] on current orders. Send current supply of meds [medications]." -Those orders indicated: --"Skin prep to bilateral heels for skin protection one time daily." --"Pressure Injury Treatment/Prevention on each shift two times a day. 1. Check that [the] air mattress is on [the] bed and operating correctly. 2. Float heels when in bed. 3. Ensure dressings are in place as ordered. 4. Pressure redistributing cushion in w/c [wheelchair]. 5. Reposition q2-3h [every two to three hours]. 6. Pericare as indicated," were noted as received 3/17/25. *His diagnoses included hemiparesis (paralysis) following cerebral infarction (a stroke) affecting the left non-dominant side, Type 2 Diabetes Mellitus, and an unstageable pressure ulcer of the right heel. *A 3/24/25 Skin Alteration Evaluation identified a new pressure injury to resident 205's right heel that measured 4.4 centimeters (cm) in length by 5.0 cm in width and was staged as a suspected deep tissue injury. *His care plan indicated: -"I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] impaired mobility. 2 [Two] staff and the hoyer lift [a full-body mechanical lift] for all transfers," was initiated on 3/18/25. -"I am dependent on staff with: roll left and right,	F 656		

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chair/bed-to-chair transfers, toilet transfers, tub/shower transfers, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, [and] personal hygiene," was initiated on 3/25/25.
-"Utilizes an [a] bariatric bed," was initiated on 3/18/25.
-"Ensure that I am wearing appropriate footwear when mobilizing in w/c," was initiated on 3/25/25.
-"I have an unstageable pressure ulcer to right lateral heel r/t AFO [ankle-foot orthosis] use. My pressure ulcer will show signs of healing and remain free from infection through the review date," was Initiated on 3/25/25.
*There was no documentation that indicated an air mattress had been utilized, trialed, or refused.
*There was no documentation that indicated that resident 205 wore blue padded pressure-reducing boots.

Interview on 4/2/25 at 8:04 a.m. and again at 11:10 a.m. with assistant director of nursing (ADON) C regarding resident 205 revealed:
*She was the wound care nurse.
*She had been on vacation when resident 205 was admitted to the facility.
*Resident 205 did not have any pressure ulcers when he was admitted on 3/17/25.
*Resident 205 had been assessed as high risk for developing pressure areas when he was admitted.
*She stated all residents were to be provided with an air mattress when they were admitted and those were only removed at the resident's request.
-Resident 205 did not have an air mattress on his bed. He had a mattress that she felt would not have "saved his heels" from a pressure ulcer.
-She had been told resident 205 refused the air

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mattress.
*Resident 205 was identified as having a pressure ulcer on his right heel on 3/24/25.
*She felt that resident 205's right heel pressure ulcer had been caused by his AFO brace (used to control ankle/foot position and movement) that his daughter had brought to the facility for him to wear.
-That brace was sent home before she had returned to work, and she had not seen that brace.
*She expected interventions including the use of an air mattress, pressure-reducing boots while in bed and while in the wheelchair, and every two-hour repositioning to have been implemented for any resident admitted and assessed as a high-risk for a pressure injury.
*She confirmed that there were no interventions, including the pressure-reducing boots, listed in resident 205's care plan before or after the identification of that pressure ulcer.
*She stated that those above interventions would not have prevented a pressure ulcer from his AFO.
*Resident 205 had been provided with those pressure-reducing boots when the pressure area was identified.
-She expected resident 205 to wear those pressure-reducing boots when he was in bed and in his wheelchair.

Interview on 4/2/25 at 12:16 p.m. with DON B regarding resident 205 revealed:
*She expected resident 205's physician's transfer orders for wound prevention should have been included in resident 205's care plan and implemented before he developed a pressure ulcer.
*His care plan should have been updated with

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F 656	Continued From page 23	F 656		

additional interventions if needed after his pressure ulcer had been identified.
*Resident 205 had been provided with pressure-reducing boots after the right heel pressure ulcer had been identified.

Interview on 4/2/25 at 12:30 p.m. with registered nurse (RN) D regarding resident 205's admission orders revealed:
*Resident 205 was transferred from another long-term care facility with orders from his physician.
*She had reviewed those admitting orders and entered the medication orders and care plan interventions.
*The treatment orders and interventions including the pressure injury treatment and prevention orders were to have been reviewed by ADON C before they were entered into the resident's EMR.
*When ADON C was unavailable to review those orders and interventions she expected DON B to review and enter them.

3. Observation and interview on 3/30/25 at 2:52 p.m. and again at 6:43 p.m. with resident 206 revealed:
*He was lying in his bed.
*A tabs alarm (a device that alerts staff with an audible sound when the resident changed position) was draped over the handle of his bedside table and hung down towards the floor.
*He stated that he had fallen recently, was getting stronger, and wanted to return home.

Observation on 3/30/25 at 6:52 p.m. with resident 206 in the dining room revealed he was seated in his wheelchair with no tabs alarm.

Observation on 3/31/25 at 8:06 a.m. with resident

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F 656	Continued From page 24 206 in the dining room revealed he was seated in his wheelchair eating breakfast and there was no tabs alarm on his wheelchair. Observation and interview on 4/1/25 at 7:30 a.m. with resident 206 revealed: *He was seated in a recliner chair outside the dining room with his wheelchair parked to the left of a recliner. *He stated that he had transferred himself to that recliner chair and was waiting to go to the dining room for breakfast. *There was no tabs alarm on his wheelchair or the recliner chair. Observation and interview on 4/2/25 at 8:39 a.m. with resident 206 revealed: *He was lying in his bed. *The tabs alarm was attached to the bedside table drawer. -He was not wearing the tabs alarm in bed. *He stated he did not know what the tabs alarm was used for and that he did not wear it while in bed or in his wheelchair. Review of resident 206's EMR revealed: *He was admitted on 3/13/25. *His diagnoses included Type 2 Diabetes Mellitus, cirrhosis of the liver, convulsions, and difficulty in walking. *Physician orders on 3/13/25 included, "Ensure tabs alarm is on at all times when in bed and his wheelchair," and "Tabs alarm on in bed and to wheelchair to notify staff of position changes ." *His care plan included: -"I am at risk for falls related to history of hepatic encephalopathy, cardiomyopathy and glaucoma," was initiated on 3/25/25. -"Tab alarm to alert staff with position changes,"	F 656		

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F 656	Continued From page 25 was initiated on 3/25/25. -"I require substantial/max assist [assistance] by staff with: roll left and right, sit to lying, sit to stand, lying to sitting on [the] side of [the] bed, chair/bed-to-chair transfers, toilet transfers, tub/shower transfers." Interview on 4/1/25 at 9:29 a.m. with CNA K revealed: *CNA K worked at the facility for approximately three months. *CNA K had found resident 206 on the floor near his bed a few weeks ago. She could not recall the date that occurred. -Resident 206 had tried to transfer himself to his bed. *Resident 206 required the assistance of one staff person to transfer him from his bed or wheelchair. *Resident 206 did not wear a tabs alarm before or after that fall. *Resident 206 had a call light that he used to request staff assistance. *CNA K reviewed information on how to care for residents from the residents' paper charts and the EMR when she completed her charting. *CNA K carried an assignment sheet that provided her with information about the residents she cared for. -That sheet was also used to provide a report to the next shift's staff. --It did not indicate that resident 206 required a tabs alarm. Interview on 4/1/25 at 9:53 a.m. with CNA F regarding resident 206 revealed: *Resident 206 did not wear a tabs alarm. *CNA F stated he would ask the nurse or look in the residents' care plan for information on how to	F 656		

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F 656	Continued From page 26 care for the residents. -He stated he reviewed those resident care plans every day. Interview on 4/1/25 at 10:03 a.m. with infection preventionist/licensed practical nurse (IP/LPN) G regarding resident 206 revealed: *She was the nurse who was working on the floor that day and was responsible for resident 206's care. *Resident 206 had a tabs monitor. -He would at times refuse to wear that tabs monitor. -IP/LPN G stated that she had ensured resident 206 was wearing that tabs alarm and he had allowed her to clip it to his shirt. *CNAs would find resident care information in the resident's care plan in the EMR. *She completed the CNA daily assignment sheets and would not have included that resident 206 wore a tabs monitor on that sheet. *IP/LPN G confirmed that resident 206's care plan included that he wore a tabs monitor. Interview on 4/1/25 at 10:34 a.m. with DON B revealed: *She expected the CNAs to look at the Kardex (a report of residents' care needs and interventions) or EMR care plans regularly for information on how to care for the residents. *She stated that a resident's need for a tabs alarm would be care planned. *She confirmed that resident 206's care plan indicated his need for a tabs alarm. *She stated a resident's use of a tabs alarm would not be on the CNA's assignment sheet. 4. Observation and interview on 3/31/25 at 9:19 a.m. with resident 34 in her room revealed: *She was sitting in her wheelchair.	F 656		

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*Her legs were wrapped with Ace bandages.
*She stated the physical therapist wraps her legs daily and it had helped reduce the swelling.

Interview on 4/1/25 at 10:39 a.m. with physical therapist M revealed:
*She wrapped resident 34's legs with Ace elastic bandages daily because it was a physician-ordered treatment for her lymphedema (fluid build-up that causes swelling).
*She had worked with the Minimum Data Set (MDS) coordinator to get the physician's orders for resident 34's Ace wrap treatments.

Review of resident 34's electronic medical record (EMR) revealed:
*She had been admitted on 12/30/24.
*She had a brief interview for mental status (BIMS) score of 15 which indicated she was cognitively intact.
*Her diagnoses included:
-Lymphedema, not elsewhere classified.
-Edema, unspecified.
-Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity.
*Resident 34's current care plan did not include her use of the Ace wraps.
-"PT/OT/ST as ordered by MD."
-"Tx and medications as ordered by MD."

Interview on 4/1/25 at 1:55 p.m. with assistant director of nursing (ADON) C regarding resident 34's lymphedema revealed:
*She knew the physical therapist was providing the Ace wrapping treatment for resident 34's lymphedema.
*She expected that treatment to be addressed in the resident's care plan.
*Staff needed to be aware of the care being

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F 656	Continued From page 28 provided. Interview on 4/2/25 at 12:05 p.m. with RN/MDS coordinator D regarding resident 34's lymphedema revealed: *The nursing staff were not trained regarding the elastic bandage wraps resident 34 needed on her legs. *She had obtained orders from resident 34's physician for the wrap treatments that therapy provided. *She did not think resident 34's use of elastic wraps needed to be part of the resident's care plan because the treatments did not involve the nursing staff. Interview on 4/2/25 at 1:30 p.m. with DON B regarding resident 34's lymphedema revealed: *She knew about the treatments for resident 34's lymphedema. *She confirmed the information regarding the lymphedema treatments was not on her care plan. *It was her expectation that information would be a part of the resident's care plan. Review of the provider's revised 9/30/24 Care Plans policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"Interventions act as the means to meet the individual's needs. The "recipe" for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met."	F 656		

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F 656	Continued From page 29 *"Care plans are accessible to all direct-care staff, including the resident's physician/provider. It is the responsibility of all direct care members to familiarize themselves with the care plan and review the routinely for changes."	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to identify and implement pressure ulcer prevention interventions to ensure facility-acquired pressure ulcers had not developed for one of two sampled residents (205) identified at high risk for skin breakdown and dependent on the staff assistance with their activities of daily living (ADL). Findings include: 1. Observation and interview on 3/31/25 at 8:38 a.m. with resident 205 revealed: *He was seated in his wheelchair and wore blue padded pressure-reducing boots on both of his	F 686	1.Resident 205's care plan has been updated to include appropriate interventions that have been implemented to assist in healing of his current pressure ulcer and prevent the development of new pressure ulcers. 2. All residents that are high risk for the development of pressure ulcers are at risk for interventions not being put in place to prevent the development of new pressures ulcers. A full house audit of all residents was completed to determine their risk for pressure ulcers, review of their care plans to ensure appropriate interventions are in place for residents that are at high risk for pressure ulcers, and care plans updated if indicated. 3. Administrator, DON, and IDT in collaboration with the medical director reviewed the Skin and Pressure Injury Prevention Program policy to ensure residents who admit to the facility without a pressure ulcer have interventions in place to prevent the development of them. This policy includes assessing and reviewing the residents' risk for developing pressure ulcers and potential interventions that could be utilized for pressure ulcer prevention including documentation and care planning of those interventions to meet the resident's skin care needs. DON or designee will educate all nursing and direct care staff on the Skin and Pressure Injury Prevention Program policy related to their role and responsibilities to ensure resident's skin care needs are identified, pressure ulcer prevention interventions are identified and implemented, and effective care planning.	5/1/2025

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F 686	Continued From page 30 feet. *He said he had been at the facility for about two weeks and did not know why he needed to wear those boots. -He stated his feet did not hurt. 2. Observation and interview on 4/1/25 at 7:59 a.m. with resident 205 and certified nursing assistant (CNA) R in resident 205's room revealed: *CNA R stated that resident 205 had been at the facility for about two weeks. *Resident 205 wore a "Tubi Grip" (compression stocking) on his right leg and blue boots on both feet due to a pressure ulcer on his right heel. *Resident 205 stated that the ulcer on his right heel did not cause him any pain. 3. Observation on 4/2/25 at 7:43 a.m. with resident 205 revealed: *He was lying in bed on his back with blue boots on both feet. *His bed did not have an air mattress on it. 4. Review of resident 205's electronic medical record (EMR) revealed: *He had been admitted on 3/17/25 from another long-term care facility. *His Braden assessment score was 18 on 3/13/25 which indicated he was as risk for developing pressure ulcers. *His Braden assessment score was 6 on 3/17/25 which indicated he was at high risk for developing pressure ulcers. -That assessment indicated he did not have a history or an existing pressure ulcer at that time. *A 3/13/25 physician's order, "Transfer to [provider] on current orders. Send current supply of meds [medications]."	F 686	4. DON or designee will audit a sample of 5 current residents to include those exhibiting a change of condition and new admissions to ensure a skin assessment is completed, Braden Scale is completed to determine risk for pressure ulcers and that all residents that are high risk for the development of a pressure ulcer have appropriate interventions implemented to prevent the development of new pressure ulcers. Audits will be completed 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 686	Continued From page 31 -Those orders indicated: --"Skin prep to bilateral heels for skin protection one time daily." --"Pressure Injury Treatment/Prevention on each shift two times a day. 1. Check that [the] air mattress is on [the] bed and operating correctly. 2. Float heels when in bed. 3. Ensure dressings are in place as ordered. 4. Pressure redistributing cushion in w/c [wheelchair]. 5. Reposition q2-3h [every two to three hours]. 6. Pericare as indicated," were noted as received 3/17/25. ---There was no documentation that indicated that those orders had been initiated upon resident 205's admission to the facility. *His diagnoses included hemiparesis (paralysis) following cerebral infarction (a stroke) affecting the left non-dominant side, Type 2 Diabetes Mellitus, major depressive disorder, pressure ulcer of the right heel, unstageable, and personal history of Staphylococcus Aureus [drug resistant organism] infection. *A 3/24/25 Skin Alteration Evaluation identified a new pressure injury to resident 205's right heel that measured 4.4 centimeters (cm) in length by 5.0 cm in width and was staged as a suspected deep tissue injury. *His care plan indicated: -"I have an ADL Self Care Performance Deficit r/t [related to] impaired mobility. 2 [Two] staff and the hoyer lift [a full-body mechanical lift and sling used to move a person's full body] for all transfers," was initiated on 3/18/25. -"I am dependent on staff with: roll left and right, chair/bed-to-chair transfers, toilet transfers, tub/shower transfers, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, [and] personal hygiene," was initiated on 3/25/25. -"Utilizes an [a] bariatric bed," was initiated on	F 686		

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F 686	Continued From page 32 3/18/25. -"Ensure that I am wearing appropriate footwear when mobilizing in w/c [wheelchair]," was initiated on 3/25/25. -"I have an unstageable pressure ulcer to right lateral heel r/t AFO [ankle-foot orthosis] use. My pressure ulcer will show signs of healing and remain free from infection through the review date," was initiated on 3/25/25. *There was no documentation that indicated: -An air mattress had been utilized, trialed, or refused as ordered by the physician at the time of his admission. -The resident wore blue padded pressure-reducing boots. -That the above pressure injury treatment and prevention interventions ordered by the physician had been care planned or implemented upon admission. 5. Interview on 4/02/25 at 8:04 a.m. and again at 11:10 a.m. with assistant director of nursing (ADON) C regarding resident 205 revealed: *She was the wound care nurse. *She had been on vacation when resident 205 was admitted to the facility. *Resident 205 did not have any pressure ulcers when he was admitted to the facility on 3/17/25. *Resident 205 had been assessed as high risk for developing pressure ulcers when he was admitted. *She stated all residents were provided with an air mattress when they were admitted and those mattresses were only removed at the resident's request. -Resident 205 did not have an air mattress on his bed. He had a mattress that would not have "saved his heels" from a pressure ulcer. -She had been told resident 205 refused the air	F 686		

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F 686	Continued From page 33 mattress. *Resident 205 was identified as having a new pressure ulcer to his right heel on 3/24/25. *She felt that resident 205's right heel pressure ulcer had been caused by his AFO brace that his daughter had brought to the facility for him to wear. -That brace was sent home before she had returned to work, and she had not seen that brace. *She expected pressure relieving interventions including the use of an air mattress, pressure reducing boots in bed and while in the wheelchair, and every two-hour repositioning would have been implemented for any resident admitted and assessed as high risk for pressure injury. *She confirmed that there were no interventions, including the pressure-reducing boots, for pressure relief listed in resident 205's care plan before or after the identification of that pressure area. *She stated that those above interventions would not have prevented a pressure injury from his AFO. *Resident 205 had been provided with those pressure reducing boots when the pressure ulcer was identified. -She expected resident 205 to wear those pressure reducing boots when he was in bed and in his wheelchair. 6. Interview on 4/2/24 at 12:16 p.m. with DON B regarding resident 205 revealed: *She expected that all the physician transfer orders and interventions should have been implemented and followed when resident 205 had been admitted including the pressure ulcer prevention orders. -Those interventions for pressure ulcer	F 686		

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F 686	Continued From page 34 prevention should have been included in resident 205's care plan before he developed a pressure ulcer and updated with additional interventions if needed after the pressure ulcer had been identified. *Resident 205 had been provided with the pressure reducing boots after the right heel pressure ulcer had been identified. *She confirmed the resident had developed the pressure ulcer after his admission to the facility. 7. Interview on 4/2/25 at 12:30 p.m. with registered nurse (RN) D regarding resident 205's admission orders revealed: *Resident 205 was transferred from another long-term care facility with orders from his physician. *She had reviewed those admitting orders and entered the medication orders and care plan interventions. *The treatment orders and interventions including the pressure ulcer treatment and prevention orders were to have been reviewed by ADON C before they were entered into the EMR. *When ADON C was unavailable to review those orders and interventions she expected DON B to review and enter them. Review of the provider's revised 9/11/24 Skin and Pressure Injury Prevention Program policy revealed: *"To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical conditions demonstrates that they are unavoidable." *"A plan of care (POC) will be put in place for residents that are identified with actual skin breakdown or at-risk for skin breakdown."	F 686		

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F 686	Continued From page 35 *"Nursing personnel will utilize the results of the physical exam and the Pressure Injury Assessment tools to determine an individualized pressure injury prevention program for each at-risk resident. This will include interventions to: a. Protect skin against the effects of pressure , friction and shear ...d. Educate staff, residents and families, e. Train front-line caregivers, f. Immediate prevention plan instituted when potential areas are identified." *Pressure can come from splints, casts, bandages, and wrinkles in the bed linen."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the implementation of their smoking policy for one of one sampled resident (11) who smoked and was not assessed for smoking risks and safety. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *She was admitted on 4/7/2016. *She had a history of being burned while smoking, preferring to smoke down to the filter of the cigarette.	F 689	1.A smoking program evaluation for risk was completed for resident 11 on March 31, 2025 at the time of survey per her quarterly schedule. 2. Resident 11 is the only resident that smokes on facility grounds and is supervised by staff. Avantara Pierre is a nonsmoking facility with an agreement signed on admission. Resident 11 had admitted to the facility prior to the implementation of the nonsmoking status. 3. Administrator or designee will educate nurse managers on the Smoking policy to ensure resident 11's smoking program evaluation for risk is completed as required per policy. Resident 11 smoking assessment review will be added to daily clinical stand-up notes for a reminder to ensure the evaluation is completed timely.	5/1/2025

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	435047	A. BUILDING _____ B. WING _____	C 04/02/2025

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 689	Continued From page 36 *Her current care plan had a focus area that indicated she preferred to smoke and had the potential for injury. That focus area was initiated on 9/28/21 and revised on 5/10/22. *Interventions for the focus area included: -Ascertain her wishes about smoking and respect her decision. -Assess her ability to smoke independently/safely. Staff were to supervise her while she was smoking. -If the weather was below zero, she was not allowed to smoke. -She was to use a cigarette extender and a protective smoking apron to prevent her from further burns when she smoked. -She could smoke per facility's smoking schedule after meals in the courtyard. -Staff were to encourage her to put out her cigarette before it got to the filter. -Staff were to stay with resident 11 while she was smoking and remind her to not make any sudden turns when smoking. -Her smoking materials were to be stored in a locked area per facility policy. *She had the following smoking program evaluation assessments completed: -An as needed assessment on 11/23/23. -An annual assessment on 9/5/24. -A quarterly assessment on 12/30/24 and 3/31/25. -No quarterly smoking program evaluation assessments were completed for her between December 2023 and August 2024. *She was hospitalized on 10/24/24 and returned to the facility on 10/26/24. -No smoking program evaluations assessment was completed upon her return to the facility on 10/26/24.	F 689	4. Administrator or designee will complete an audit of resident 11's smoking program evaluation for risk to ensure it has been completed timely. This audit will be completed monthly x 3 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 689	Continued From page 37 2. Interview on 4/01/25 10:17 a.m. with certified nursing assistant (CNA) F revealed: *Resident 11 had needed to have staff present when she smoked. *There were no set smoking times. *Resident 11's cigarettes were locked up in a cabinet. *CNA's had access to that cabinet. 3. Interview on 4/01/25 at 10:53 a.m. with licensed practical nurse (LPN) E revealed: *Resident 11 had not been smoking for approximately the last three weeks. -She had paranoid schizophrenia and had stated that someone told her she should not be smoking. -Her smoking supplies were kept in a locked cupboard in the activities room. -She was to have staff stay with her while she smoked. *Assessments including the smoking program evaluation assessments, could be completed by floor nurses. *The assessments would automatically appear red in the EMR system when they were due, and that was how she would know she needed to complete an assessment. 4. Interview on 4/2/25 at 7:44 a.m. with registered nurse (RN) D revealed: *She or director of nursing (DON) B would complete the user-defined assessments (UDA's) for a resident's smoking risk. *She said the floor nurses had never completed the resident's smoking risk evaluations. *Those smoking assessments were required to be completed quarterly at the same time the resident's minimum data set (MDS) assessments was completed.	F 689		

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F 689	Continued From page 38 *She had worked on 10/24/24 when resident 11 was hospitalized. *She had worked between December 2023 and August 2024. *She felt she could have missed resident 11's assessment's during those above dates. *She stated their EMR system did not automatically populate the resident's smoking program evaluation assessments for completion. 5. Interview on 4/2/25 at 8:15 a.m. with assistant director of nursing (ADON) C revealed: *She did not complete the residents' smoking program evaluation assessments and was unsure of how often they were to be completed. *She thought that DON B had completed those assessments before. 6. Interview on 4/2/25 at 10:20 a.m. with DON B revealed: *She or RN D would complete the residents' smoking program evaluation assessments. *Those assessments did not auto-populate in their EMR system for them to complete. *Floor nurses did not complete those assessments. *She stated she assumed resident 11's smoking risk assessments between December 2023 and August 2024 and upon her readmission after her hospitalization on 10/24/24 were missed. *She expected staff to follow their policy for when the smoking program evaluation assessments should be completed. Review of provider's 2/10/24 revised Smoking Policy revealed: *"If the facility allows smoking, all residents who smoke will be assessed for their ability to safely smoke with or without assistance or supervision	F 689		

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F 689	Continued From page 39 and such will be included on the [resident's] care plan. The Smoking Assessment will be completed at admission, readmission, quarterly, annually and with a change in condition."	F 689		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.	F 847	1. Resident 34 did not enter into an arbitration agreement upon admission to the facility on December 30, 2024. Resident 34 has since discharged from the facility on April 14, 2025. Resident 1 admitted to the facility on January 6, 2012, excluding him from a signed arbitration agreement with Avantara Pierre. A new arbitration agreement has been completed with residents 3, 13, 16, 25, 27, 28, 30, 31, 33, 35, and 37 to ensure these residents were explicitly granted the right to rescind the agreement within 30 calendar days of signing it. The following residents that were identified have not entered into an arbitration agreement: 5, 7, 10, 11, 12, 15, 19, 21, 22, 24, 26, 29, 36, 38, 40, 41, 42, 43, 44, 46, 47, 48, 50, 105, 106, 115, 156, 204, 205, 206, 304, and 305. The following identified residents that have since discharged from the facility had not entered into a binding arbitration agreement: 4, 34, 39, 104, and 154. No immediate corrective action could be taken for residents 2 and 20 who had entered into an arbitration agreement due to having since discharged from the facility. 2. All residents were at risk for entering into an arbitration agreement that indicated the resident had 10 days to rescind the agreement. 3. The Administrator will educate the social services designee on the Arbitration Agreement policy. In addition, the Administrator has provided the social services designee with a new arbitration agreement form which includes information on residents' rescission rights of 30 days. Education will occur no later than May 1, 2025.	5/1/2025

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F 847	Continued From page 40 §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, Voluntary Agreement for Arbitration review, and policy review, the provider failed to ensure 50 of 55 residents (1, 2, 3, 4, 5, 7, 10, 12, 13, 15, 16, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 50, 104, 105, 106, 115, 154, 156, 204, 205, 206, 304, 305) who had entered into an Arbitration Agreement upon admission to the facility were explicitly granted the right to rescind the agreement within 30 calendar days of signing it. Findings include: 1. Observation and interview on 3/31/25 at 1:25 p.m. with resident 34 in her room regarding the Voluntary Agreement for Arbitration addendum she had signed upon admission revealed she: *Knew she signed several papers when she was admitted. *Was not sure what a Voluntary Agreement for Arbitration was for.	F 847		

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F 847	Continued From page 41 *Did not recall signing a Voluntary Agreement for Arbitration specifically. Review of resident 34's electronic medical record (EMR) revealed: *She was admitted on 12/30/24. *She had a Brief Interview for Mental Status (BIMS) score of 15 which meant she was cognitively intact. *Her 12/30/24 admission agreement was signed by resident 34. *The admission packet included information regarding arbitration. 2. Review of the provider's undated Voluntary Agreement for Arbitration agreement revealed: *"The execution of this Arbitration Agreement is voluntary and is not a precondition to receiving medical treatment at or for admission to the Facility." *"The Resident and/or Legal Representative understands that this Arbitration Agreement may be rescinded by giving written notice to the Facility within 10 days of its execution. If not rescinded within 10 days of its execution, this Arbitration Agreement shall remain in effect for all claims arising out of the Resident's stay at the Facility." 3. Interview on 4/2/25 10:19 a.m. with administrator A regarding the amount of time a resident had to rescind the arbitration agreement revealed: *All residents were offered arbitration upon admission. *The social services director went over the arbitration agreement during the admission process with the resident and/or their representative.	F 847		

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F 847	Continued From page 42 *Arbitration was not a condition for admission to the facility. *No residents had used the arbitration process to settle a dispute. *He was not sure why the corporate agreement allowed 10 days for a resident/responsible party to rescind the agreement. *He agreed it should be 30 days in the arbitration agreement according to the requirements. *All residents would have signed the same agreement. *50 of the 55 current residents (1, 2, 3, 4, 5, 7, 10, 12, 13, 15, 16, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 50, 104, 105, 106, 115, 154, 156, 204, 205, 206, 304, 305) admitted after the 2019 arbitration agreement implementation and had signed arbitration agreements. *The five residents who did not have those signed agreements were admitted prior to the 2019 arbitration agreements being implemented. *The social services director was not available for an interview during the survey. 4. Review of the provider's undated Arbitration Agreement policy revealed: *"It is the policy of Avantara Pierre ("Facility") to present the Arbitration Agreement to Resident/Resident's Legally Authorized Representative (Representative") after the admission paperwork is completed." *"Not require any resident or his/her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at a facility." *"Provide the resident or his/her representative a 30-day rescission period."	F 847		

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F 880 F 880 SS=E	Continued From page 43 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880	1. No immediate corrective action could be taken for the failure of CNA J and CNA S not wearing a gown when providing assistance to resident 205 with personal hygiene. Appropriate disinfecting agent has been purchased for the whirlpool tub. All nursing staff will be trained on the proper disinfecting process for the whirlpool tub. The oscillating fan mounted to the wall adjacent to the entrance door of the laundry room was removed from the wall. The area under the wall-mounted chemical system has been repaired and painted. New flooring for the laundry room, to include the cracked flooring that had exposed concrete and cracked flooring below the mechanical lift slings, has been received and is awaiting vendor installation. The slings stored in the clean linen room have been washed to ensure no buildup of gray dust. The hooks in the clean linen room have been raised on the wall to ensure the mechanical lift slings are not touching the floor. The paint that was peeling on the wall below the mechanical slings has been repaired and painted. A cleaning log for April has been posted in the laundry room. 2. All residents are at risk for adverse effects related to failure to ensure appropriate infection prevention practices were followed.	5/1/2025

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F 880	Continued From page 44 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and manufacturer's manual review, the provider failed to ensure appropriate infection control practices were followed for: *Enhanced barrier precautions (EBP) (gloves and gown use when providing direct contact care) by two of two certified nursing assistants (CNAs) (J and S) for one of one sampled resident (205) with a catheter, multidrug-resistant organism (MDRO),	F 880	3. The DON or designee will educate all nursing care staff, to include CNA J and CNA S, on the Enhanced Barrier Precautions policy. The DON or designee will educate all nursing staff on the process for cleaning of the whirlpool tub. The Administrator or designee will educate all laundry staff, to include maintenance director H and laundry aide L, on the Linen and Laundry Handling policy including education to ensure the laundry room is clean and free of needed repairs that cause risk for infection. The DON or designee will educate all staff on the Infection Prevention Program policy. Education will be completed no later than May 1, 2025 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 880	Continued From page 45 and a pressure injury. *Appropriate whirlpool (WP) tub cleaning by two of two CNAs (F and I) in one of two WP tub rooms used for bathing residents. *Maintaining the cleanliness of the laundry room. Findings include: 1. Observation on 3/30/25 at 5:26 p.m. with resident 205 revealed: *There was a sign on his door that indicated "Stop Enhanced Barrier Precautions Everyone must: Clean their hands, including before entering and leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities dressing bathing/showering, transferring, changing linen changing briefs, or assisting with toileting..." *Resident 205 was in bed and had been rolled on his side facing the window. *CNA J and CNA S were providing resident 205 assistance with personal hygiene and changing his undergarments. *CNA J and CNA S had gloves on but did not have gowns on while they assisted resident 205. Interview on 3/30/25 at 5:37 p.m. with CNA S regarding the above observation revealed: *She stated that the EBP sign on resident 205's door meant that she needed to wear gloves and a gown when she emptied his catheter. *She confirmed that she and CNA J had been wearing gloves but no gowns when they changed resident 205's undergarments. *She did not think they needed to wear a gown when they provided the above care, because they did not empty his catheter. Review of resident 205's electronic medical record (EMR) revealed:	F 880	4. The DON or designee will complete an audit of 5 residents that require enhanced barrier precautions to ensure staff are utilizing the appropriate personal protective equipment when providing residents assistance with personal hygiene. The DON or designee will audit 5 samples of staff to ensure the proper procedure for the cleaning of the whirlpool tub is being completed. The Administrator or designee will audit the laundry room to ensure there is no oscillating fan mounted on the wall, the wall in the laundry room does not require any repairs or painting, the flooring in the laundry room and clean linen room is free of cracked flooring and exposed concrete, the slings stored in the clean linen room are free of dust build-up and are hanging off the floor. The cleaning log in the laundry room will also be audited to ensure it has been posted and fully completed. 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 880	Continued From page 46 *He had been admitted on 3/17/25. *His diagnoses included, a pressure ulcer of the right heel, unstageable, and personal history of Staphylococcus Aureus (a bacterial) infection. *His care plan indicated: -"I am on Enhanced Barrier Precaution r/t [related to] catheter and wound care." -"Ensure that gown and gloves are used during high-contact resident care activities of catheter cares, draining of Foley catheter and wound care that provide opportunities for transfer of MDROs to staff hands and clothing." Interview on 4/1/25 at 10:08 a.m. with infection preventionist/licensed practical nurse (IP/LPN) G regarding EBP revealed she expected staff to wear both a gown and gloves while providing direct care, such as personal hygiene and changing undergarments to residents with catheters and wounds. 2. Observation and interview on 4/1/25 at 10:49 a.m. with CNA I and CNA F in the west WP tub room of the cleaning and sanitizing process of the resident WP tub revealed: *Both CNA I and CNA F used the WP to bathe residents that day. *CNA I took a spray bottle of Micro-Kill Q10 disinfectant cleaner from the cabinet and sprayed the surfaces of the WP tub. *CNA F indicated that the Micro-Kill Q10 was not the correct cleaner for the WP tub and took a spray bottle of BruTab 6S cleaner/disinfectant from that same cabinet. -That spray bottle of BruTab 6S was not dated, the bottle's label was worn, and there was no indication of the time the surface needed to remain wet with that product to achieve	F 880		

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 04/02/2025

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 880	Continued From page 47 sanitization. *There were instructions for cleaning the WP tub posted and taped to the front of that cabinet. *CNA F sprayed the surfaces of the tub and tub seat with the BruTab 6S spray, stated he would wait 10 minutes, and then used the shower sprayer to rinse down the surfaces. *CNA F stated that was the process used to clean and sanitize the WP tub between each resident's bath. *CNA I and CNA F confirmed there was no brush used to clean the tub. Observation and interview on 4/1/25 at 2:08 p.m. with director of nursing DON B in the west WP tub room revealed: *She expected the CNAs to clean the WP tub with the BruTab 6S cleaner and that the surface needed to remain wet for 10 minutes. -That spray bottle's contents had been made with an effervescent tablet of that cleaner. -That was the last bottle of that cleaner. -Staff were to use that bottle until it was gone. -She confirmed that the spray bottle was not dated to indicate when it had been mixed with the tablet. --She confirmed that it did not indicate the time the surface needed to remain wet to achieve sanitization. *Staff could also have used the Micro-Kill Q10 cleaner to clean the whirlpool. -That bottle was refilled from a larger bottle of Micro-Kill Q10. -It was not dated when it had been filled. -She confirmed that it did not indicate the time the WP tub surface needed to remain wet to achieve sanitization. *She expected the staff to follow the posted manufacturer's guidelines when using and	F 880		

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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 880	Continued From page 48 cleaning the whirlpool. -Those guidelines stated to " ...spray all surfaces of the tub with Dispatch Cleaner and Disinfectant." -She confirmed that the CNAs had not followed the manufacturer's guide for cleaning the WP tub. *They did not have the Dispatch Cleaner and Disinfectant listed in the WP tub's manufacturer's manual. Review of the BruTab 6S safety data sheet indicated it was: *"Stable: 1 [One] week shelf life when diluted into a closed container." Review of the WP cleaning instruction sheet that was observed taped to the cabinet in the west WP tub revealed it was a copy of page 23 of the WP manufacturer's manual. Review of the provider's eSide Entry Whirlpool Tubs manufacturer's manual review revealed: *"The tub MUST be cleaned and disinfected after each use." *"Clean and disinfect the tub after EACH use to avoid resident infection and contamination of the tub." *" Read and understand ALL information on disinfecting BEFORE use. ALWAYS wear rubber gloves, an apron and a face shield when using disinfectant." *"Use of unapproved cleaners will dry out the rubber seals and gaskets and the tub will not function properly." *Page 23 of the manual indicated, "Perform these procedures in the following order: 1. Use the drain plug to close the drain. 2. Remove and disassemble all jet assemblies. Lay all pieces in the bottom of the tub.....4. Clean the pieces and	F 880		

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AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

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F 880	Continued From page 49 spray all surfaces of the tub with Dispatch Cleaner and Disinfectant. Take a long handled brush and thoroughly clean surfaces of the tub and the jet casings. 5. Allow the Dispatch Cleaner and Disinfectant to sit on the surfaces for one minute. 6. Rinse all surfaces and pieces in the footwell of the tub with water. 7. Use a clean towel to dry all tub surfaces ..." 3. Observation and interview on 4/2/25 at 9:18 a.m. with laundry aide L in the facility laundry room revealed: *Laundry aide L had worked at the facility for approximately 3 years. *She stated that the laundry staff were responsible for cleaning the laundry room. *There was an oscillating fan mounted to the wall adjacent to the entrance door. -That fan blew air from the side of the laundry room where the soiled linens were brought in and loaded into the washing machines towards the area where the laundry aide folded the clean linens. *There was an area under the wall-mounted chemical system approximately two feet by two feet where the paint was peeled and had exposed concrete. *The area of the floor near that chemical system had more than three areas two inches by five inches where the tiles were cracked or peeling and were uncleanable surfaces. *Laundry aide L stated those areas were from when the chemicals leaked. The leak had been fixed but the floor and wall had not been repaired. -She could not recall when that leak had occurred and stated it had been "a while," and that maintenance was aware of those areas. *In the clean linen room there were hooks on the wall that held the mechanical lift slings.	F 880		

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F 880	Continued From page 50 -More than six of those lift slings touched the floor and had thick gray dust on them. *The area below the slings had an area of approximately three inches by two feet of cracked or missing tiles and peeling paint on the wall. -Laundry aide L was not sure if maintenance was aware of those areas. Observation and interview on 4/2/25 at 9:41 a.m. with maintenance director H in the laundry room revealed he: *Was aware of the areas near the wall-mounted chemicals that needed repair. -Had not ordered tiles to replace the cracked ones. *Was not aware of the areas on the wall or the cracked flooring in the clean linen room. *Agreed that the missing tiles and the peeling paint made the floor and walls uncleanable surfaces. *Confirmed the wall-mounted fan was placed in a spot where it would blow air from the dirty side to the clean side of the laundry room and indicated he would move that fan. Observation and interview on 4/2/25 at 12:08 p.m. with IP/LPN G in the laundry room revealed: *She confirmed that the above areas were not cleanable surfaces. *She expected that the laundry room areas would have been maintained and cleaned regularly. *The fan had been removed from the wall. *The mechanical lift slings had been hung in a position where they no longer touched the floor. *Maintenance director H was responsible for the laundry department, and she had been unaware of the above-observed infection control concerns. *She confirmed that there had been no April cleaning log.	F 880		

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F 880	Continued From page 51 Review of the provider's revised 6/21/24, Enhanced Barrier Precautions policy revealed: *"Enhanced Barrier Precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities." *"Enhanced Barrier Precautions (EBP) should be used for all residents with wounds or indwelling devices." *"Gowns and Gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ...Dressing ...Changing briefs or assisting with toileting ..." Review of the provider's Laundry Room Daily Sweep/Mop/Dust logs revealed: *There was no log for April 2025 *The March 2025 log indicated: -Sweeping and mopping had not been completed on 3/24/25, 3/25/25, 3/27/25, 3/28/25, 3/29/25 , or 3/30/25. -Dusting washers and dryer shelves had not been completed on 3/1/25, 3/2/25, 3/5/25, 3/8/25, 3/9/25, 3/12/25, 3/15/25, 3/16/25, 3/19/25, 3/23/25, 2/24/25, 3/25/35, 3/27/25, 3/28/25, 3/30/25 or 3/30/25. Review of the provider's revised 2/28/25 Infection Prevention Program Policy revealed: *"The facility-wide comprehensive infection prevention and control program addresses detection, prevention, and control of infections among residents and personnel. It is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and	F 880		

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AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

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F 880	Continued From page 52 infections."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 on 4/1/25 Avantara Pierre was found not in compliance with the following requirements: E004 and E006.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004	1. The emergency preparedness plan was reviewed on 4/24/2025. All memorandums of understanding/agreements were reviewed. The emergency and non-emergency transfer agreement that had not been updated since 4/9/2021 was removed from the emergency preparedness plan. The emergency and non-emergency transfer agreement has been revised and is awaiting signature from St. Mary's hospital. 2. All residents have been identified to be at risk for the emergency preparedness plan memorandums of understanding/agreements not being updated annually. 3. The Administrator will review the emergency preparedness plan at least annually to ensure the memorandums of understanding/agreements have been updated annually. 4. The Administrator or designee will review the emergency preparedness plan monthly for the next three months to ensure all memorandums of understanding/agreements have been updated annually. Results of the audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the interdisciplinary team (IDT) and Medical Director of analysis and recommendation for continuation/discontinuation/revision of review based on findings.	5/1/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chase Watson	Administrator	4/25/2025

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

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 _____	04/01/2025

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 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan agreements (evacuation transfer) annually. Findings include: 1. Record review on 4/1/25 at 3:38 p.m. revealed no documentation that the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the transfer agreement had not been updated annually since 4/9/21. Interview with the administrator at that same time confirmed that finding. He stated they did not have a more current agreement.	E 004		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2),	E 006		

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	435047	A. BUILDING _____ B. WING _____	04/01/2025

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 006	Continued From page 2 §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be	E 006	1. The emergency preparedness plan was reviewed on 4/24/2025. The emergency operations plan that had last been reviewed on 7/31/2021 has been removed from the emergency preparedness plan and was replaced with the document – introduction: emergency preparedness plan for Avantara Pierre. The risk assessment that had not been updated since 2017 was removed from the emergency preparedness plan and a new hazard and vulnerability assessment was completed on 4/24/2025 2. All residents are at risk for the facility not updating its hazard and vulnerability assessment annually. 3. The Administrator will review the emergency preparedness plan at least annually to ensure the hazard and vulnerability assessment has been updated. 4. The hazard and vulnerability assessment was completed on 4/24/2025. The hazard and vulnerability assessment will be completed annually when necessary.	5/1/2025

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 _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 006	Continued From page 3 reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan annually (emergency operations plan and risk assessment). Findings include: Record review on 4/1/25 at 3:40 p.m. revealed no documentation that the provider's current emergency preparedness plan was updated annually. For example, the emergency operations plan had last been reviewed on 7/31/2021 and the risk assessment had not been updated annually since 2017. Interview with the administrator at that same time confirmed that finding. He stated they did not	E 006		

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 _____	04/01/2025

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 006	Continued From page 4 have a more current update for that assessment.	E 006		

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 _____	**04/01/2025**

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 was conducted on 4/1/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Pierre was found in compliance.	K 000		5/1/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chase Watson	Administrator	4/25/2025

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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 _____	04/02/2025

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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/30/25 through 4/2/25. 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 44:73, Nursing Facilities, was conducted from 3/30/25 through 4/2/25. Avantara Pierre was found not in compliance with the following requirement: S165.	S 000		
S 165	44:73:02:18 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the residents admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing and interview the provider failed to ensure the facility was operated in a manner to avoid injury and danger to the occupants in one randomly observed location (activities/social room). Findings include: Observation and testing on 4/1/25 at 1:21 p.m. revealed the unattended combination oven/range in the activities/social room was provided with	S 165	1. The oven range switch in the activity/social room was immediately shut off during discovery at the time of survey on 4/1/2025. The oven range was removed from the activity/social room on 4/4/2025. 2. All residents have been identified to be at risk for potential injury or danger due to the oven range switch being turned on. The therapy department has an oven range with an on/off switch to the appliance that is used for therapeutic training. The therapy department has secured doors that are locked which prevents access for residents when therapy staff are not present. 3. The Administrator will educate maintenance director H and all therapy staff to ensure the oven range switch in therapy is shut off when it is not actively being used for therapeutic training. Education will occur no later than May 1, 2025, 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.	5/1/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chase Watson	Administrator	4/24/2025

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 _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK 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) COMPLETE DATE
S 165	Continued From page 1 power. Testing of that range-top at that same time revealed the burners would turn on and heat up when their respective knobs were turned to an on position. That range top being able to be turned on created a condition where a cognitively impaired resident could injure themselves or create a fire hazard. Further observation and testing at that same time revealed that oven/range had been previously provided with a disconnect switch in the base cabinet to its right. Interview with the maintenance supervisor at that same time confirmed those findings. He went on to reveal it was his understanding that the disconnect was supposed to be turned off when that device was not attended.	S 165	4. The Administrator or designee will conduct five audits of the oven range switch to ensure it is turned off when not being used for therapeutic training. Audits will be weekly for four weeks, and then monthly for two months. Results of the audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the interdisciplinary team (IDT) and Medical Director of analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	