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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH STREET RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/13/22 through 9/15/22. Avantara North was found not in compliance with the following requirements: F600, F658, F686, F812, and F849. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/13/22 through 9/15/22. Areas surveyed included: quality of care and treatment, nursing services, and dietary services. Avantara North was found not in compliance with the following requirements: F686 and F812.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Celina Sahre
TITLE: Administrator
(X6) DATE: 10/6/22

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

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F 600	Continued From page 1 and policy review the provider failed to ensure one of one resident (17) had received physician ordered treatment of a wound for seven consecutive opportunities. Findings include: 1. Observation and interview on 9/13/22 at 11:29 a.m. of wound care for resident 17 by registered nurse (RN) I revealed: *A a dressing on her lower back with a date of 9/9 written on it. -That was the date of the last dressing she had placed on the wound. *The dressing was to have been changed daily. *She confirmed the dressing with the 9/9 date written on it indicated the dressing had not been changed since 9/9. -That was four days the dressing had not been changed. *There was small amount of thick, gray matter that came out of the wound when she had pressed around the edges of it. *She stated the wound may be infected and would need an antibiotic, and she was going to notify the doctor. Review of resident 17's medical record revealed: *Her 8/13/22 Brief Interview of Mental Status was a score of 2, meaning the she had severe cognitive impairment. *Her diagnoses included: abnormal posture, mild cognitive impairment, severe intellectual disabilities, and osteoarthritis. *Her care plan included she: -Had the potential for impairment to skin integrity related to incontinence and difficulty understanding due to developmental delays. -Required assistance for getting dressed, assistance with cleaning up after using the toilet, and with personal hygiene.	F 600	1. This incident was reported to the Department of Health (DOH) immediately after the Administrator was notified of the event on 9/15/22. All proper authorities were notified and the final investigation with interventions was accepted by DOH on 9/19/22. The incident was substantiated, and the Administrator and Human Resource Director provided education on the Abuse and Neglect Legacy West policy to staff I, H, B, and the other nurses identified in the investigation. 2. All residents are at risk for adverse effects relating to the failure to follow physician orders. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the policy for Following Physician Orders and Abuse and Neglect Legacy West. The DON or designee will educate all nurses on the Following Physician Orders policy to ensure treatment and dressing changes are completed per physician's order. The Administrator or designee will educate all staff on the Abuse and Neglect Legacy West policy to ensure all residents remain free from abuse and neglect. Education will occur no later than October 28th, and those not in attendance due to vacation, sick leave, or casual work tatus will be educated prior to their first shift worked. 4. The DON or designee will audit five residents to ensure treatment orders and dressing changes are completed per physician orders. The Administrator or designee will interview 5 residents to ensure they feel safe in the facility and are free from abuse and neglect. Audits and interviews will be weekly for four weeks, and then monthly for two months. Results of the audits will be discussed by the Administrator/DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/1/22

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F 600	Continued From page 2 *A skin evaluation on dated 8/19/22 revealed on her left lower back she had a small red bump with a center head showing, and moderate drainage from the center. *A physician order dated 8/20/22 to cleanse sore on lower left back every day with normal saline and to keep it clean and dry. *A physician order dated 8/23/22 on the treatment administration record (TAR) to apply warm compresses to her lower left back site every evening shift. *A skin evaluation dated 8/26/22 revealed a wound of a small red raised bump on lower back area that was to be cleansed daily. *The TAR revealed the wound care treatment had been documented seven consecutive time, from the evening of 9/9/22 through the evening of 9/12/22, as having been completed when it had not been. Interview on 9/15/22 at 1:46 p.m. with nurse supervisor H regarding wound care for resident 17 revealed she: *Did wound rounds and evaluated wounds once per week. *Had completed wound rounds on 9/11/22. *Had forgotten resident 17 had a wound and had not looked at on 9/11/22. -She had not looked at the wound since the previous week. Interview on 9/15/22 at 3:04 p.m. with nurse supervisor H and assistant director of nursing (ADON) B regarding wound of resident 17 revealed: *The wound was a "boil" and nurse supervisor H thought the dressing had been a dry dressing, but was not certain. *The TAR would have shown the correct order for	F 600		

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F 600	Continued From page 3	F 600		

treatment of the wound.
*If a treatment had not been completed the documentation should have reflected that in the TAR.

Continued interview and record review on 9/15/22 at 3:12 p.m. with ADON B regarding 17's wound revealed:
*His expectation would have been for the documentation to be accurate.
*He confirmed he had worked as the charge nurse on 9/10/22 and 9/11/22.
-He had documented the wound treatment for resident 17 as being completed on those dates, for a total of two times.
-He agreed that the dressing dated 9/9/22 indicated the treatment had not been provided for that wound since that date.
-He confirmed that:
--The wound care documentation indicated the wound dressing had been completed, although it had not been done.
--He had not completed the wound dressing on 9/10/22 and 9/11/22.
--He had documented the wound dressing as being done.
--He confirmed other nurses had documented that they had completed the wound dressing for the evening of 9/9/22 through the evening of 9/12/22.
---He confirmed that not having the dressing changed during that time period may have resulted in the gray, thick matter the wound had developed.

Interview on 9/15/22 at 4:12 p.m. with administrator A regarding wound documentation revealed:
*Her expectation was for documentation to be

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accurate.
-When a treatment had not been completed as ordered, the nurse should have documented why it was not done.
-The nurse should have notified the next shift so that they could have completed the treatment.
*She stated "I think it is neglect and should be reported [to the South Dakota Department of Health]."

Review of nurse supervisor H's signed job descriptions revealed she was:
*To complete "Wound Care Rounds."
*"12. Administer or supervise all treatments prescribed by physicians including but not limited to pressure ulcer care, Foley catheter care, and hot and cold compounds."
*"15. Provide wound care when needed."

Review of ADON B's signed job description revealed:
*"Essential Functions".
-"1. Assists the D.O.N. [director of nursing services] with planning, directing, and supervising the activities of the nursing staff.
-2. Ensure the Nursing Department is in compliance with federal, state, and local regulations."

Review of the provider's revised May 2021 following physician orders policy revealed:
*"Policy: to correctly and safely receive and transcribe physician's orders so correct order is followed/administered."
-"If the order is for a medication or treatment, it should be entered in the MAR/TAR [medication administration record/treatment administration record]."
*The policy did not cover documentation of

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F 600	Continued From page 5 administering or not administering medications or treatments. Review of the provider's abuse and neglect policy revealed: *"Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, ... neglect, or mistreatment." -"Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires, but fails to provide that service."	F 600		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *One of one sampled resident (22) received appropriate medical professional psychiatric monitoring of psychiatric medications and accurately documented fall risk evaluation. *One of one sampled resident (45) received a timely assessment and documented assessment of a reported skin injury. 1. Review of resident 22's medical record	F 658		

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F 658	Continued From page 6 revealed: *She was admitted on 5/12/20. *Her 7/13/22 Brief Interview of Mental Status (BIMS) score was a three, indicating she had severe cognitive impairment. *Her diagnoses included: traumatic brain injury, schizophrenia, neurologic neglects syndrome, epilepsy, attention and concentration deficit, cognitive communication deficit, dementia, and other diagnoses. *Physician orders included the following anti-psychotic medications: -OLANZapine 10 mg once a day for schizophrenia. -OLANZapine 5 mg once a day for schizophrenia. -QUEtiapine Fumarate 75 mg once a day for schizophrenia. --This had been decreased from 150 mg on 9/1/22. *Her care plan included: -A revised 6/2/20 focus of potential alterations to mood/psychosocial well-being related to: repeated accidents and falls, diagnosis of schizophrenia, dementia and use of psychotropic medication. --Revised 6/17/22 interventions included: Psychiatric support with a psychiatrist, with an attempt to switch providers to a local psychiatric provider so resident would not need to travel. -A revised 7/27/20 focus of aggressive/inappropriate behavior including yelling, cussing, threatening behavior, hitting, grabbing, and mimicking staff related to diagnoses of dementia and schizophrenia. --Revised 6/17/22 interventions included: give psychoactive medication as ordered and refer to mental health provider as needed or indicated. -A revised 6/15/22 focus of using psychoactive medications for schizophrenia and to be followed	F 658	1. Resident 22 has an appointment scheduled for 10/19/22 at 9am with Dr. Helleckson at Monument Health. Social Services Designee (E) completed a house audit with the IDT to ensure all residents identified needing psychological services, have it or will be offered these services. Immediate education was provided to MDS Nurse F on the Skin Program policy to include proper evaluation, documentation, and reporting upon identification at the time of survey. 2. All residents are at risk for adverse effects related to failure to provide needed psychological services and failure to receive a timely and documented assessment following identification of a skin injury. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Skin Program policy. The Administrator or designee will educate the IDT, to include Social Services Designee (E), on ensuring residents requiring psychological services are receiving the appropriate services to address their psychological needs. The DON or designee will educate all nursing staff on the Skin Program policy to ensure residents receive a timely and documented assessment of a reported skin injury. Education will occur no later than October 28th, and those not in attendance due to vacation, sick leave, or casual work tatus will be educated prior to their first shift worked. 4. The Administrator or designee will audit five residents to ensure they have psychological services if it is deemed necessary. The DON or designee will audit 5 residents' medical records to ensure that a timely and documented assessment of any skin injury has been completed. Audits will be weekly for four weeks, and then monthly for two months. Results of the audits will be discussed by the Administrator/DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/1/22

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F 658	Continued From page 7 by psychiatrist "but currently trying to get switched to local psychiatry group that can come see her in facility." *Her progress notes included: -*A 3/1/22 behavior and psychotropic interdisciplinary team (IDT) review indicated she had been seeing a psychiatrist. -There was no documentation to support when she had last seen a psychiatrist. *A facsimile had been sent to her psychiatrists office on 3/21/22 regarding her psychotropic medications. -A 4/9/22 facsimile was returned from her psychiatrists office indicated she had been last seen on 10/13/20 and should follow up with her primary care provider or to schedule an appointment with the psychiatrists office. *A 4/13/22 facsimile to her primary care provider had been sent requesting further advise on pharmaceutical therapy. -A 4/14/22 facsimile response was provided by her primary care provider stating she should be followed by a psychiatrist. *A 5/23/22 progress note that an attempt to contact her psychiatrist had been made and the provider was waiting on a call back. *A 5/24/22 behavior and psychotropic IDT review indicated she had been seeing a psychiatrist with attempts to change over to a new one. -There was no documentation to support when she had seen a psychiatrist. *Documentation of her behaviors from 8/25/22 through 8/30/22 included: -Eight episodes of inappropriate behavior including one or more of the following: yelling, screaming, kicking, hitting, pushing, grabbing, pinching, scratching, spitting, wandering, abusive language, threatening behavior, rejection of care. *Documentation of her behaviors from 9/1/22	F 658		

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F 658	Continued From page 8 through 9/14/22 included: -Twelve episodes of inappropriate behaving including one or more of the following: yelling, screaming, wandering, grabbing, abusive language, and rejection of care. Interview on 9/15/22 at 1:50 p.m. with social service designee (SSD) E regarding psychiatric care for resident 22 revealed: *SSD did not always document care provided. *SSD was responsible to coordinate psychiatric care, including filling out paperwork for referrals and contacting physicians for assistance in obtaining referrals. *Her psychiatrist had not provided care recently. -SSD was not certain when she last seen a psychiatrist. *SSD had been working on getting a different psychiatric provider but had not always documented this. *SSD had contacted the current psychiatrist and had been told they "had not seen in her a while". *The certified nurse practitioner provider had been adjusting her psychiatric medications, including QUEtiapine Fumarate. *There had been a decrease in the QUEtiapine Fumarate on 9/1/22. -She had been really "snippy" lately but had not been abusive or mean. -She had been having inappropriate behavior prior to the decrease of the QUEtiapine Fumarate. Interview on 9/15/22 at 4:09 p.m. with administrator A regarding resident 22's psychiatric care revealed she was unaware she was not receiving care from a psychiatrist and would have benefited from seeing one.	F 658		

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F 658	Continued From page 9 Psychiatric visit notes for resident 22 were requested from the administrator on 9/15/22 at 1:25 p.m. the only notes provided were from 8/22/19 which was prior to resident 22's admission on 5/1/20. A policy for psychiatric care was requested from the administrator on 9/15/22 at 1:25 p.m. Regional Nurse Consultant C stated there was no policy for this. 2. Observation on 9/13/22 at 3:10 p.m. of resident 22 revealed: *She was in the hallway. *She attempted to stand up from her wheelchair. *A CNA assisted her in sitting back down and put her feet on the wheelchair pedals. Review of resident 22's medical record revealed: *She was admitted on 5/12/20. *Her 7/13/22 Brief Interview of Mental Status (BIMS) score was a three, indicating she had severe cognitive impairment. *Fall risk evaluations had been completed for her falls on 5/27/22, 5/29/22, and 6/23/22. *She had a fall on 7/2/22 at 5:45 a.m. -This fall resulted in a left tibia fracture. *On 7/2/22 her fall risk evaluation with an effective date of 5:45 a.m. indicated: -She had not just had a fall. -She did not have a fall incident in the last three months. *She did have three falls within the last three months as indicated by the fall risk evaluations being completed on 5/27/22, 5/29/22, and 6/23/22. Continued interview and record review on 9/15/22 at 3:17 p.m. with ADON B regarding	F 658		

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F 658	Continued From page 10 documentation revealed: *Resident 22 fell "often". *He had not been aware of any issues with documentation. *His expectation would have been for the documentation to be accurate. *Agreed the 7/2/22 fall risk evaluation was incorrect as resident 22 did have a fall that resulted in the fall risk evaluation being completed on that date. Interview on 9/15/22 at 4:12 p.m. with administrator A regarding accuracy of assessments revealed she would have expected the documentation to always be accurate. Review of the provider's falls management policy revealed: *"POLICY It is the policy of the facility to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence." -"Fall injury prevention - Post Fall". --"4. Complete Fall Risk evaluation". 3. Review of resident 45's electronic medical record revealed: *A 6/21/22 skin alteration evaluation that showed she had an abrasion on her lower back. -There was no description or measurements of the abrasion. *A 6/23/22 progress note that a certified nursing assistant reported she had a large bruise on her shoulder. *A 6/23/22 skin evaluation that showed no skin issues. Observation on 9/13/22 at 9:27 a.m. of resident 45 in her room revealed:	F 658		

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F 658	Continued From page 11 *She was lying in her bed that was in the lowest position. -Next to the bed there was a mattress. -Next to that mattress there was a fall mat that extended to the dresser against the opposite wall. Review of resident 45's record revealed: *A 6/21/22 skin alteration evaluation that showed she had an abrasion on her lower back. -There was no description or measurements of the abrasion. *A 6/23/22 progress note that a certified nursing assistant reported she had a large bruise on her shoulder. *A 6/23/22 skin evaluation that showed no skin issues. Interview on 9/15/22 at 11:29 a.m. with certified nursing assistant (CNA) R regarding resident 45's bruise revealed: *She confirmed she had reported the bruise to a nurse. -The bruise was "large" about the size of an orange or apple. -She was not certain if a nurse had evaluated the bruise. Interview on 9/15/22 at 11:40 a.m. with MDS Nurse F regarding the bruise on resident 45 revealed she: *Remembered talking to the director of nursing about the bruise. -Had not documented this conversation. *Confirmed the bruise should have been documented on the 6/23/22 skin evaluation, and investigated. Interview on 9/15/22 at 11:03 a.m. with assistant director of nursing B regarding the bruise on	F 658		

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F 658	Continued From page 12 resident 45 revealed: *The bruise had not been evaluated and documented, and should have been. *Had provided skin program training to the professional nurses on 6/30/22. Interview on 9/15/22 at 11:29 a.m. with certified nursing assistant (CNA) R regarding resident 45's bruise revealed: *She confirmed she had reported the bruise to a nurse. -The bruise was "large" about the size of an orange or apple. -The nurse did not evaluate the bruise at the time of it being reported, to her knowledge. Interview on 9/15/22 at 11:40 a.m. with MDS Nurse F regarding the bruise on resident 45 revealed she: *Remembered talking to the director of nursing about the bruise. -Had not documented this conversation. *Confirmed the bruise should have been documented on the 6/23/22 skin evaluation, and investigated. Interview on 9/15/22 at 11:03 a.m. with assistant director of nursing B regarding the bruise on resident 45 revealed: *The bruise had not been evaluated and documented, and should have been. *Had provided skin program training to the professional nurses on 6/30/22. The director of nursing was not available for an interview. Review of the provider's revised April 2021 Skin Program policy revealed:	F 658		

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F 658	Continued From page 13 *"6. When a pressure injury, bruise or skin tear is noted, a Skin Evaluation UDA [user defined assessment] should be completed, and the injury entered into Risk Management in PCC [electronic medical record]. These areas will be monitored on Treatment Administration Record (TAR) until healed. Following identification of a skin issue, the Skin Alteration Evaluation UDA will be completed weekly until resolved."	F 658		
F 686 SS=D	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 ensure: *One of one sampled resident (27) received a continuously working pressure reduction alternating air mattress to promote the healing of a pressure ulcer. *One of one sampled resident (50) received a continuously working pressure reduction alternating air mattress to prevent a pressure ulcer.	F 686		

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F 686	Continued From page 14 Findings include: 1. Observation and interview on 9/13/22 at 9:40 a.m. with resident 27 revealed: *She was sitting up in her bed, dressed and groomed. *She had a pressure ulcer on her right buttocks. *She had the pressure ulcer at home before she moved into the facility. *She was supposed to have a pressure reduction mattress. -Her current mattress was hard, and her bottom was sore. -She had been on the hard mattress for 2 days. *The only time she was got out of bed was to use the bedside commode. *Dressings for her pressure ulcer were done daily in the mornings before 6 a.m., "they do it after I get off the commode." *She ate her meals in bed with the use of her overbed table. *She stated, "they are short of help, last night was the worst night." -At 8:00 p.m. she activated her call light to get assistance in getting on the commode. --It was almost 9 p.m. when someone came and assisted her with getting on the commode, they did not return and assist her off of it until 10:00 p.m. Interview on 9/14/22 at 1:02 p.m. with registered nurse (RN) G regarding resident 27's pressure ulcer revealed: *She was admitted with a stage three pressure ulcer to her right buttock and still had that stage three pressure ulcer. *She previously had a pressure reduction alternating air mattress to promote healing of the pressure ulcer.	F 686	1. Resident 27 and Resident 50 both have pressure reducing alternating air mattresses in place, and in working condition. An audit of all residents requiring a pressure reducing alternating air mattress has been completed to ensure they are in place and functioning appropriately. 2. All residents requiring the use of a pressure reducing alternating air mattress to promote wound healing is at risk if an air mattress is not in place and functioning appropriately. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Skin Program policy. The DON or designee will educate all nursing staff on the Skin Program policy, to include the use of pressure reducing air mattresses to promote wound healing, to ensure air mattresses is in place and functioning appropriately. Education will occur no later than October 28th, and those not in attendance due to vacation, sick leave, or casual work tatus will be educated prior to their first shift worked. 4. The DON or designee will audit five residents requiring the use a pressure reducing air mattress to promote wound healing is in place and is functioning appropriately. Audits will be weekly for four weeks, and then monthly for two months. Results of the 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 findings.	11/1/22

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F 686	Continued From page 15 -That pressure reduction alternating air mattress had stopped inflating and was replaced with a different mattress that was not a pressure reduction alternating air mattress. Observation and interview on 9/14/22 at 1:14 p.m. with resident 27 revealed: *She was sitting up in bed crying and was refusing to eat her lunch. *The facility had placed a different pressure reduction alternating air mattress on her bed. *The air mattress was under inflated and sagging in the middle. -She was laying on the underinflated sagging portion of the air mattress and was crying. *She stated her buttocks hurt and she had wanted to sit on her commode. *Her call light was placed on. *The assistant director of nursing (ADON) B answered her call light. -He stated they were having issues with some of their air mattresses. -They were in the process of getting a different air mattress to replace the one that was not inflating. *The resident was transferred onto her bedside commode per her request. Review of resident 27's medical record revealed: *She was admitted to the facility on 7/13/21. *A 7/13/21 admission Minimum Data Set (MDS) assessment documented a stage three pressure ulcer. *Her most recent Brief Interview for Mental Status (BIMS) dated 7/15/22, had a score of 15 which means she was cognitively intact. *Her diagnoses included stage three pressure ulcer of right buttock, unilateral primary osteoarthritis of the left hip, primary osteoarthritis of unspecified shoulder, other chronic pain, protein calorie malnutrition, muscle wasting and	F 686		

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F 686	Continued From page 16 atrophy, pressure-induced deep tissue damage of the right buttock. *Physician's orders for: -Severe Pain related to CELLULITIS OF BUTTOCK; PRESSURE-INDUCED DEEP TISSUE DAMAGE OF RIGHT-BUTTOCK". -Check air mattress if functioning properly as needed. *Care plan intervention initiated on 8/24/21 for "I will use an air mattress on bed and cushion in w/c [wheelchair]for pressure relief and comfort." Interview on 9/15/22 at 1:05 p.m. with certified nursing assistant (CNA) J regarding resident 27 revealed: *The resident had a pressure ulcer to her right buttock. *She had come to the facility with the pressure ulcer. *She stated, "She has a different air mattress; the previous mattress broke." Interview on 9/15/22 at 2:36 p.m. with nurse supervisor licensed practical nurse (LPN) and ADON B regarding resident 27 revealed: *She had a stage 3 pressure ulcer on admission to the facility. -That pressure ulcer was not healed. -That pressure ulcer was due to immobility. *She does not get out of bed, except to use the bedside commode. *Her air pressure reduction mattress had not been working correctly. *She now had an air pressure reduction mattress that was working. 2. Observation on 9/13/22 at 1:07 p.m. and 4:42 p.m. of resident 50 revealed:	F 686		

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F 686	Continued From page 17 *With his door open, resident 50 was lying in bed sleeping. -He was wearing an incontinent brief and no pants. *The door to his room was open. *He had a urinal on his bedside table and a bedside commode in the corner of his room. *There was a walker next to his closet. *There was no alternating air pressure reduction mattress on his bed. *His mattress he did have was firm to the touch. Observation and interview on 9/14/22 at 1:32 p.m. with RN G revealed: *With his door open, resident 50 was lying in bed sleeping. -He was wearing an incontinent brief and no pants. *The door to his room was open. *He had a urinal on his bedside table and a bedside commode in the corner of his room. *There was a walker next to his closet. *There was no alternating air pressure reduction mattress on his bed. -The mattress he did have was firm to the touch. *He had a stage three facility acquired pressure ulcer to his coccyx. -He did not have this pressure ulcer when he was admitted on 6/28/22. *His reluctance to reposition caused the pressure ulcer. *He slept a lot. *He did not walk, was weak and stayed in bed. *She agreed the mattress he was laying on was not a pressure reducing alternating air mattress nor a pressure reduction mattress. *His alternating air mattress had stopped working correctly and they were in the process of getting him a different one.	F 686		

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F 686	Continued From page 18 *Following wound care and interview, ADON B presented to resident 50's room with a pressure reducing alternating air mattress and placed it on his bed. Observation on 9/14/22 at 4:00 p.m. of resident 50 revealed: *An alternating air mattress was on his bed. *The air mattress was not inflated and was on the bed. -He was laying on top of this un-inflated air mattress. *ADON B agreed the mattress was not inflated and stated he would replace that one with a different air mattress. Observation and interview on 9/15/22 at 1:12 p.m. with resident 50 revealed: *With his door open, resident 50 was lying in bed. -He was wearing an incontinent brief and no pants. *The door to his room was open. *He moved to the facility because of his "rheumatism." *His pressure ulcer was on his coccyx, and it had developed in the facility. -"I think I was laying on all this wet stuff." -"They put me in a wheelchair when I go to medical appointments, otherwise I stay in bed, I am too weak to walk." -"I could walk before I came in here." -"I told one of the ladies to tell the therapy people to put me on their list and she said they only work half a day." -No one was helping him with exercises in bed. *He had an air mattress and then it broke. -He was unsure of how long it took to get the new air mattress. -The staff had come and helped turn him.	F 686		

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F 686	Continued From page 19 -He was rolled over to his right side and laid there for half of the day. *He had a urinal and bedside commode for going to the bathroom. Review of resident 50's medical record revealed: *He was admitted on 6/28/22. *His current diagnoses included rheumatoid arthritis, weakness, pain in right and left shoulder and other joints, history of venous thrombosis and embolism, stage three pressure ulcer. *His most recent BIMS dated 8/17/22 had score of 14 indicating he was cognitively intact. *His 7/5/22 admission MDS had documented that he: -Had no current pressure ulcer. -Was at risk for the development of a pressure ulcer. *Braden Scale and Clinical Evaluations were completed on: -On 7/5/22 and 7/12/22 that revealed he was at low risk for pressure ulcer development and that: --His skin was rarely moist: skin was usually dry. --He walked occasionally. --He had no mobility limitations. --Nutrition was excellent and ate most every meal. --Friction and sheer were no apparent problem. -On 7/22/22, 8/11/22, and 8/19/22 that revealed he was at high risk for pressure ulcer development and that: --His skin was occasionally moist: Skin is occasionally moist. --He was chairfast: ability to walk severely limited or nonexistent. --Nutrition was probably inadequate. --Friction and shear were a potential problem. *Skin Evaluations were completed: -Weekly from 7/5/22 to 7/26/22 with no skin	F 686		

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F 686	Continued From page 20 alterations identified. -The 7/27/22 skin assessment indicated he had a skin alteration but did not have a description of what or where the alteration was. -The weekly skin assessment dated 8/3/22 had no alteration in skin integrity documented. -The weekly skin assessment dated 8/26/22 had documentation of an unstageable pressure ulcer to the coccyx. *Skin alteration evaluations were documented: -On 8/29/22 indicating he had an unstageable pressure ulcer. -On 9/12/22 indicating he had a stage three pressure ulcer. *Physician orders for: -"Alternating air mattress on bed check Q [every]shift for proper functioning and settings." *Care Plan focus was documented as: -Resident "is at risk for impairment to skin integrity r/t [related to]poor appetite with weight loss, occasional incontinence of bladder, limiting mobility d/t [due to]pain in hip." Date Initiated: 06/28/2022 Revision on: 08/24/2022". -Resident "has an actual impairment to skin integrity Open area. Unstageable on coccyx area Date Initiated: 08/26/2022 Revision on: 08/26/2022". *Care plan goal was documented as: -Resident "will continue to have intact skin through next review. Date Initiated: 06/28/2022 Revision on: 09/01/2022". -"Resident will not develop signs and symptoms of infection on the wound site Date Initiated: 08/26/2022 Revision on: 09/01/2022". *Care Plan interventions included: -"Maxi float mattress [pressure reduction air mattress] and w/c [wheelchair] cushion in place." -"LOW RISK -Skin weekly. Report abnormalities to the nurse".	F 686		

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F 686	Continued From page 21 -"Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD." -"Alternating air mattress on bed date initiated: 08/26/2022." -"Wound care to Coccyx". *Physical therapy treatment notes included: -6/30/22 Physical therapy started walking using a four wheeled walker, patient ambulated approximately 80 feet today with cues on upright standing with minimum assist, one time, and was followed closely by wheelchair. -7/4/22 He had performed NuStep four minutes and two minutes with a rest break. Therapeutic exercises to increase bilateral lower extremity endurance, cardiovascular endurance, and cardiopulmonary endurance. He had ambulated 50 feet and 80 feet with a four wheeled walker with minimum assist to improve functional capacity and endurance. *Physical Therapy discharge summary was documented as: -A baseline on 6/29/22 of having been able to ambulate 40 feet with a four wheeled walker and with caregiver assistance. -A discharge on 8/2/22 of having been able to ambulate 250 feet with a four wheeled walker, with caregiver assistance, and one rest break due to fatigue. Interview on 09/15/22 at 12:54 p.m. with CNA J regarding resident 50 revealed: *The CNA's observed residents' skin during cares. *Changes in skin condition were reported to the charge nurse on duty. *Staff were made aware of the resident's daily care needs by the resident call light, care sheets,	F 686		

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F 686	Continued From page 22 shift report and the morning huddle. *He had a pressure ulcer to his coccyx. -He did not have that pressure ulcer when he was admitted to the facility. *She was unsure if his pressure ulcer had improved or gotten worse stating "I haven't seen it for a few days, so I don't know." *Pressure ulcer interventions had included: *An air mattress on his bed. -She stated, "He had one prior to yesterday but it had not worked so we had taken it off until they got one that worked." Interview on 9/15/22 at 2:32 p.m. with nurse supervisor LPN H and ADON B regarding resident 50 revealed: *Nurse supervisor LPN H was the facility's wound care nurse. -She was not wound care certified. -She had completed: -- A webinar regarding wound care. --A wound care seminar in another town. -She worked with a wound care company that assisted with treatment recommendations and provided education regarding the proper utilization of wound care products. -That company employed a nurse who came to the facility to do this. -She could call that nurse with specific wound care concerns. *That nurse visited the facility monthly but had not visited in the last month. *Resident 50 was at risk for the development of a pressure ulcer. *He had a facility acquired stage three pressure ulcer to his coccyx. *He did not have an alternating air mattress prior to the development of his pressure ulcer. *Interventions in place once he had developed a	F 686		

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F 686	Continued From page 23 pressure ulcer had included: -An alternating air mattress, but it had quit working so they had put him back on a regular mattress until they could get a different air mattress. *Nurse supervisor LPN H completed a weekly wound assessment that included measurements to monitor the wound progress and the effectiveness of the interventions. *The wound measurements had not improved. *The depth of the wound had increased. *Staff were monitored to ensure they were implementing care plan interventions by her completing observation rounds twice a day. *There had been a concern identified regarding the development and management of pressure ulcers in the spring of 2022. *The facility's policies and procedures regarding care, treatment, prevention, and interventions for pressure ulcers had included the use of pressure reduction alternating air mattresses. Interview on 9/15/22 at 4:30 p.m. with administrator A regarding the facilities Quality Assurance Plan Improvement (QAPI) process revealed: *Pressure ulcers were identified as a facility systemic failure concern during a MOCK survey conducted in the spring of 2022. -This systematic failure concern had been reviewed to the QAPI committee. -A nurses meeting was held on 6/30/22 to discuss the skin program with education provided. -Audits had been started in June 2022. *There was no documentation to support the audits had continued. Review of the facility's 12/1/2019 Treatment Nurse job description revealed:	F 686		

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F 686	Continued From page 24 *"Summary/Objective" -"The Treatment Nurse is responsible for performing skin treatments for all guests under their care. This position will obtain treatment orders for attending physicians and assist with modifying the treatment regimen in accordance with established policies and procedures. The Treatment Nurse will provide supervision of staff and will safeguard the health, safety and welfare of all guests under their care by following applicable laws, regulations, and established nursing policies and procedures." *"Essential Functions" -"8. Ensure that guest care plans are being followed and assess each guest's status in accordance with their care plan." -"10. Must be knowledgeable of individual care plans and support the care planning process by reporting specific information and observations of the guest's needs, preferences and report any behavioral changes." -"15. Reports all hazardous conditions, damaged equipment, accidents/incidents and supply issues to appropriate person." -"16. Maintains the comfort, privacy and dignity of guests and interacts with them in a manner that displays warmth, respect and promotes a caring environment." -"17. Ensure each guest receives person centered care." Review of facility's 4/2021 Skin Program policy revealed: *"Policy: -To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable.	F 686		

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F 686	Continued From page 25 -To provide care and services to prevent pressure injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds." *"Procedure:" -"5. A comprehensive wound assessment will be completed:" --"c) A review of the resident's current POC [plan of care] and medical status-any other possible risk factors, impaired healing due to diagnoses;" -"7. Nursing personnel will develop a plan of care (POC) with interventions consistent with resident and family preferences, goals and abilities, to create an environment to the resident's adherence to the pressure injury prevention/treatment plan. POC to include Impaired mobility, Pressure relief, nutritional status and interventions, Incontinence, skin condition checks, Treatment, Pain Infection, Education of resident and family, Possible causes for pressure injury and what interventions have been put in place to prevent."	F 686		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH STREET RAPID CITY, SD 57701

(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 812	Continued From page 26 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to maintain one of one kitchen and one of one dishwashing room in clean or repaired condition for the floors and walls. Findings include: 1. Observation on 9/13/22 at 8:45 a.m. of the kitchen revealed several uncleanable surfaces: *A three door freezer with floor tiles missing directly in front of the freezer measuring approximately 6 feet by 3 feet. *The bottom portion of the wall by the coffee machine was missing the interior portion of the sheetrock. -Pipes were exposed. -Jagged edges of the remaining sheet rock were exposed. Observation on 9/15/22 at 2:01 p.m. of the kitchen and dishwashing room revealed: *The floor tiles in the dishwashing room had several cracks varying in size from approximately one inch to four inches. *The metal vent grill on the bottom of the front of one freezer had one vent panel unattached on one side. -This metal vent grill had built up dust on it approximately one fourth of an inch high. *Stains and multiple cracks in the floor varying in sizes from one-half inches to five inches under	F 812	1. Kitchen and dish room tiles have been ordered from Thornton Flooring on 9/23/22 and will be installed when they are able to schedule the installment. The wall with missing sheet rock will be repaired on 10/3/22. The metal vent grill on the bottom of the font freezer was reattached and cleaned on 10/3/22. 2. All residents are at risk for adverse effects related to uncleanable surfaces in the kitchen. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the F812 regulation. The Administrator or designee will educate dietary manager (D) and all dietary staff to ensure the kitchen and dishwashing room floors walls and vents are clean and in good repair. Education will occur no later than October 28th, and those not in attendance due to vacation, sick leave, or casual work tatus will be educated prior to their first shift worked. 4. The Administrator or designee will audit the kitchen environment to ensure the kitchen and dishwashing room floors, walls and vents are clean and in good repair. 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 QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/1/22

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F 812	Continued From page 27 the food preparation table in the middle of kitchen. *The floor tiles under the steamer, ice machine, and in front of the range oven and griddle were visibly soiled and stained. *Multiple cracks and stains under the sinks varying in size from one inch to three inches. *The back door of the kitchen was missing pieces of tile in front of it, in two spots, measuring approximately nine inches by three inches and one and a half feet by two and a half inches. Interview on 9/14/22 at 1:33 p.m. with dietary manager D regarding the physical environment of the kitchen revealed: *The flooring was approximately eight years old. *It was very slippery and had caused employees to fall. *She thought it was going to be replaced for the last five years. *The wall had been removed over a month ago, due to a leak causing mold buildup on it. Interview on 9/15/22 at 3:55 p.m. with administrator A regarding the physical environment of the kitchen revealed: *It was "a work in progress". *The wall by the coffee machine was removed as it had mold on it. -This was due to a three compartment sink that had leaked on the opposite side of the wall. -The wall had not been replaced, as there had been a change in maintenance personnel. *She had received a quote for flooring for the kitchen on 9/14/22. -There was not a date set for the floor to be replaced.	F 812		
F 849 SS=D	Hospice Services	F 849		

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F 849	Continued From page 28 CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the	F 849	1. Resident 16 and Resident 18 have both Hospice plan of care and comfort pack orders in their hospice binders. The hospice plan of care is integrated with the facilities care plan. A house audit was completed to ensure all hospice residents have proper documentation in their binders. 2. All residents receiving hospice services are at risk for adverse effects related to having comfort pack orders and lack of integration of hospice plan of care with facility care plan. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Hospice Services policy. The DON or designee will educate the IDT and all professional nurses on the Hospice Services policy to ensure comfort pack orders are received and the hospice plan of care is integrated with the facility care plan for all residents receiving hospice services. Education will occur no later than October 28th, and those not in attendance due to vacation, sick leave, or casual work tatus will be educated prior to their first shift worked. 4. The DON or designee will audit all the hospice residents to ensure proper comfort pack orders are in place and their hospice plan of care is received and integrated into their care plan with the facility. Audits will be weekly for four weeks, and then monthly for two months. Results of the 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 findings.	11/1/22

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F 849	Continued From page 29 LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies	F 849		

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F 849	Continued From page 30 determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the	F 849		

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F 849	Continued From page 31 provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial	F 849		

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F 849	Continued From page 32 well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *One of three sampled residents (18) had comfort pack orders. *Two of three sampled residents (16 and 18) had integration of hospice plan of care with facility care plan. 1. Observation and interview on 9/14/22 at 4:30 p.m. with resident 18 revealed: *She was sitting in a high-back wheelchair. *She had answered simple questions. *Nodded "yes" when she had been asked if she was receiving hospice care. *She had been unable to tell the surveyor why she was receiving those services or when they had started. Review of resident 18's significant change Minimum Data Set (MDS) assessment dated 6/28/22 had revealed: *The assessment was completed due to resident 18 and her representative electing hospice services. *Her Brief Interview for Mental Status (BIMS) was six, which indicated severe cognitive impairment. *She had been understood by others and could understand others. *She had required extensive assistance of two staff members for bed mobility, transfers, and toileting, and extensive assistance of one staff member for eating. *Her diagnoses had included: severe protein-calorie malnutrition, unspecified, transient cerebral ischemic attack, unspecified history of traumatic brain injury, B 12 deficiency anemia,	F 849		

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F 849	Continued From page 33	F 849		

dementia without behavioral disturbance, intervertebral disc degeneration, lumbar region, polycystic kidney, adult type, dysphagia, oral phase, and cognitive communication deficit.

Review of resident 18's medical record revealed:
*Her hospice admission had been 6/21/22 with the diagnosis of severe protein-calorie malnutrition.
*A hospice care plan and comfort care pack orders for resident 18 were requested from the administrator on 9/14/22 at 5:55 p.m.
-The comfort care pack contains physician's orders for pain medication, antianxiety medication and other medication used for end-of-life care.
*On 9/15/22 at 9:20 a.m., the hospice care plan and comfort care pack were received for resident 18 and revealed:
-A fax date of 9/15/22 at 9:17 a.m. from the hospice provider.
*Her facility care plan had been initiated on 7/8/22, with two of the interventions revised on 9/15/22.

Interview on 9/15/22 at 4:00 p.m. with Social Service Director E regarding resident 18's care plan revealed:
*The hospice care plan and comfort pack orders had not been in the binder and included with the facility care plan and they should have been.

2. Observation on 9/13/22 at 3:06 p.m. of resident 16 revealed she:
*Had been laying in her bed.
*Had not responded to questions.
*Did wave her hand in a gesture of hello.
*Was very thin in appearance.

Review of resident 16's medical record revealed:

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F 849	Continued From page 34 *She was admitted to the facility on 1/17/19. *She was admitted to hospice in March of 2022 for adult failure to thrive and end-stage dementia. *Her 6/28/22 BIMS score was 00, meaning she had severe cognitive impairment. *Her diagnoses included: senile degeneration of brain, Alzheimer's disease, major depressive disorder, respiratory failure, abnormal weight loss, malnutrition, heart failure, anxiety, and a stage 3 pressure ulcer of right buttock. *Her care plan had included an intervention of referring to her hospice care plan located in her hospice binder. -There was not a hospice care plan in her hospice binder. Interview on 9/15/22 at 3:24 p.m. with assistant director of nursing B regarding hospice care revealed: *The director of nursing was the primary care coordinator with the hospice provider and responsible for obtaining the plan of care. *The hospice provider was at the facility weekly. *There was a "binder" for each hospice patient that contained information related to care provided by hospice. *He was aware that the hospice plan of care and the facility care plan were to have been integrated. *He was not aware that resident 16 did not have a hospice plan of care in her binder. Interview on 9/15/22 at 8:48 a.m. with administrator A and MDS nurse F revealed: *They had requested a hospice plan of care from the hospice provider several times over the last few months. *The hospice provider had not provided a plan of care.	F 849		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/13/22 through 9/15/22. Avantara North was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Celina Lahre
TITLE: Administrator
(X6) DATE: 10/6/22

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2022**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/13/22. Avantara North was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Celina Lohse

TITLE

Administrator

(X6) DATE

10/6/22

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.

South Dakota Department of Health

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	10665	A. BUILDING: _____ B. WING _____	09/15/2022

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/13/22 through 9/15/22. Avantara North was found not in compliance with the following requirements: S296 and S301.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the	S 296	1. Dietary Manager (D) has been enrolled in the Certified Dietary manager (CDM) program on 8/28/22. She will complete this course within 18 months of her enrollment. Dietary Manager (D) and Dietary Aide (Q) will be enrolled in the serve safe program and have it completed by 10/31/22. 2. All residents are at risk for adverse effects of untrained dietary staff. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the S296 regulation. The Administrator or DON/Designee will ensure Dietary Manager (D) will complete the CDM course timely and ensure a minimum of two dietary staff are serve safe certified. 4. The Administrator or DON/Designee will audit the dietary department monthly for three months to ensure the department meets the needs of having a minimum of two serve safe certified staff as well as the Dietary Manager (D) continue the CDM program. Results of the audits will be discussed by the Administrator/DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Celina Lohre

TITLE: Administrator

(X6) DATE: 10/6/22

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
	10665	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 N 7TH ST RAPID CITY, SD 57701

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S 296	Continued From page 1 residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, and policy review, the provider failed to ensure the dietary manager and at least one cook were ServSafe certified. Findings include: 1. Interview on 9/15/22 at 10:00 a.m. with dietary manager (DM) D revealed: *She had worked at the facility since 6/4/18 and in her current position approximately six months. *She was aware the DM and at least one cook working in the kitchen were required to have a current ServSafe certificate. *No dietary staff including herself, had a current ServSafe certificate. *She had registered for the ServSafe class on 9/6/22 but no other employees were registered. *Since May 2022 she would often would fill in as a cook and dietary aide due to staffing issues and had not had time to ensure all cooks had received the education or registered for the ServSafe class. Interview on 3/23/22 at 1:40 p.m. with administrator A revealed: *The DM and at least one cook were required to have a current ServSafe certificate. *The dietary manager and other dietary staff were not currently ServSafe certified. The provider did not have a specific policy for dietary training.	S 296		

South Dakota Department of Health

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S 301	Continued From page 2	S 301		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and dietary training review, the provider failed to ensure: *Required dietary training (food safety, handwashing, food handling/preparation techniques, food-borne illness, serving/distribution procedures, leftover food handling policies, time/temperature controls for food preparation/service, nutrition, hydration, and sanitation requirements) had been completed prior to working independently by five of five (K, L, M, N, and O) newly hired dietary employees. *One of one dietary aide (P) had received training to operate the dishwasher prior to operating it independently. Findings include: 1. Review of the dietary training logs from 1/24/22 through 9/6/22 revealed cook K, dietary aide L, dietary aide M, cook N, and dietary aide O, all staff had been hired in 2022. The training for these employees did not include the following required topics: *Food safety *Handwashing *Food handling/preparation techniques *Food-borne illness	S 301	1. Education on food safety, handwashing, food handling, preparation techniques, food-borne illness, serving/distribution procedures, leftover food handling policies, time/temperature controls for food, nutrition, hydration, and sanitation requirements were assigned on Relias to all dietary staff to include staff members K, L, M, N, and O on 9/26/22. This initial education will be completed by 10/31/22, and those not working prior to that date due to vacation, sick leave, or casual work status will be educated prior to their work shift. 2. All residents are at risk for adverse effected related to uneducated dietary staff. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the S301 regulation. The Administrator or DON/Designee will conduct a dietary staff meeting to review this regulatory requirement. Education will occur no later than October 28th, and those not in attendance due to vacation, sick leave, or casual work tatus will be educated prior to their first shift worked. 4. The Administrator or DON/Designee will audit all new dietary staff for three months to ensure proper in-service training prior to working independently is completed. Results of the audits will be discussed by the Administrator/DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/1/22

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S 301	Continued From page 3 *Serving/distribution procedures *Leftover food handling policies *Time/temperature controls for food preparation/service *Nutrition *Hydration *Sanitation requirements Interview on 9/15/22 at 10:00 a.m. with dietary manager (DM) D regarding dietary training revealed: *The policy for training new staff was to review all training in the dietary education 2022 book. *Staff in-services for required training had been completed since May 2022. *Most of the dietary staff were new and had started in the past year. *New staff received a week of on-the-job training. -Cooks were trained by DM and shown everything the DM "knows about cooking". -Dietary aides were trained by dietary aide Q and were provided a list of daily tasks written down by dietary aide Q. -Staff are asked at end of the week of training if they were comfortable and if they were not, they were offered more training. *She often filled in as a cook or a dietary aide since May 2022 due to staffing issues and had not had time to ensure staff received the required education. *She was aware of the required training. *She was responsible to ensure all dietary staff received the required training. *She expected education requirements to be completed as a new hire before working independently. Interview on 9/15/22 at 1:20 p.m. with administrator A regarding the required dietary training revealed:	S 301		

South Dakota Department of Health

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S 301	Continued From page 4 *The required training had not been completed. *Her expectation was that new staff completed the required training before working independently. *She had not ensured the required trainings were completed. Interview on 9/15/22 at 1:55 p.m. with dietary aide P revealed she: *Started working on 6/21/22 and had worked for a month doing vital signs before she started working as a dietary aide. *Worked independently in the kitchen without any dietary training. *Had not received a lot of training *Figured out a lot of things on her own that had not been shown to her. *Used the dishwasher approximately a week before being trained on how to properly operate the dish washer. *Should have been trained before working independently. The provider did not have a specific policy for dietary training.	S 301		
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 9/13/22 through 9/15/22. Avantara North was found in compliance.	S 000		