STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 8/28/23 through 8/31/23. Avantara Redfield was found not in compliance with the following requirements: F584 and F600. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/28/23 through 8/31/23. Areas surveyed included resident rights that included residents bathing schedules, quality of care that including staffing, nursing services including grievances filed and staff using vape and marijuana pens on the premises. Avantara Redfield was found not in compliance with the following requirement: F600.	F 000		
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	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Forgey	Administrator	9/22/23

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 584	Continued From page 1 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 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 and a cleaning checklist for housekeepers the provided failed to ensure a clean and homelike environment that included the following: *A handwashing sink in the dining room that had noticeable water damage and one of the doors were hanging off the hinge. *A cracked half-wall located in the resident's shower room. *A resident's door opening only halfway and leaving grooves in the floor. *Paint on a heating unit in a resident's room is peeling away. *A wall heating unit in the dining room was that pulling away from the wall.	F 584	1. The handwashing sink was replaced on 9/21/23. The half wall in the shower room was repaired on 9/18/23. Resident #35's door was adjusted to open fully on 9/15/23 and the scratched flooring was replaced on 9/19/23. Resident #2's heat register was painted on 9/18/23. The heat register in the dining room was repaired on 9/15/23. The non exit door was cleaned on 8/30/23. The non used screws in the walls were removed on 8/31/23. Precision Drywall submitted a proposal to remove the wallpaper, resurface the walls and paint the walls on 9/19/23. Precision Drywall estimates that the company will begin the work in early November 2023. 2. The Administrator or designee will provide education to all staff regarding providing a safe, clean, comfortable and homelike environment and utilizing TELS to document areas needing repair or cleaning by 10/6/23. Those not in attendance will be educated prior to their first shift worked. 3. The Maintenance Director or designee will audit 3 random rooms, one common area and one hallway weekly x 3 months to ensure and safe, clean, comfortable and homelike environment. Results of audits will be presented by the Maintenance Director or designee at the monthy QAPI meeting for discussion of effectiveness and recommendations.	10/6/23

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F 584	Continued From page 2	F 584		

*Spider webs around a non-exit door.
*Multiple non-used screws in the wall.
*Wallpaper in multiple places throughout the facility was bubbling and peeling away from the wall.

1. Observation on 8/29/23 8:32 a.m. in the main dining room revealed:
*A handwashing sink was located next to the entrance to the kitchen.
-It had noticeable water damage located at the bottom front and side.
-The right-side door had fallen off the hinge and was hanging down.

Observation on 8/29/23 at 9:00 a.m. in the resident's shower room revealed:
*A wheeled high-back chair was sitting against the wall that had a handheld shower-head and a long hose connected to the wall.
*A cracked half-wall that contained bottles of shampoo, conditioner, and body lotion were sitting on top of it.
-The crack started at the top of the half wall and went down the outside approximately three feet and inside less than a foot.

Observation and interview on 8/29/23 at 9:48 a.m. in resident 35's room revealed:
*The door was opened halfway.
*She was sitting in her chair and waved at me to come in.
-When attempting to open the door, the door was stuck and there were visible grooves in the floor.
*She could not remember how long the door has been difficult to open.

Observation on 8/29/23 at 1:58 p.m. in resident 2's room revealed:

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F 584	Continued From page 3 *The light-colored bathroom heater unit had multiple spots with the paint peeling away, leaving dark brown spots in those areas. Interview on 8/31/23 at 10:03 a.m. with maintenance director C revealed he: *Stated the sink in the dining room had a water leak and they have a different one on order that will match the rest of the countertops in the dining room *Agreed the half-wall in the resident's shower room was a safety and sanitary issue for the residents. *Stated he has had to file down two other doors that were getting stuck and leaving grooves in the resident's floors. *Agreed the residents heater unit needed to have been repaired or replaced. *Stated the staff were to use the electronic TELS system to put in work orders for identified issues. Interview on 8/31/23 at 10:54 a.m. with administrator A and DON B revealed they: *Stated the sink in the dining room was brand new, a pipe leaked and ruined the bottom part of it and they were getting a new one to match the rest of the countertops and cabinets. *Stated the humidity has been the issue with the resident's doors getting stuck and hard to open. -Stated maintenance director C could have sanded down the door for more ease to open and close it. *Stated they have had contractors come and complete a walk through of all the resident's rooms. -Have been talking to a local painter to come in and paint the resident's rooms. *Agreed the crack in the half-wall in the resident's shower room needed to have been fixed.	F 584		

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F 584	Continued From page 4 2. Observation from 8/28/23 to 8/30/23 of non-exit door number 8 revealed: *There were thick spider webs around the door, around the frame and the doorway. Interview on 8/30/23 at 3:30 with housekeeper G, and administrator A revealed: *The door-way was not used but should have been cleaned daily. *Agreed that it had not been cleaned for some time. Review of the undated Next Level Hospitality Services Detailed Cleaning Check Off List revealed: *"6 Sanitized all doors and door frames." 3. Observation on 8/31/23 at 8:30 of the north, south and west hallways revealed: *Fourteen areas where unused screws were left in the walls. *Fourteen areas where wallpaper was separating, bubbling and peeling from the wall. 4. Observation on 8/31/23 at 10:30 a.m. in dining room revealed: *On the north wall of the dining room, the heating register was separated from the wall and exposing a crack where the sheet rock ends and the register hangs down. 5. Interview on 8/31/23 with maintenance director C revealed he: *Never noticed all the screws in the hallways and agreed they should have been removed. *Agreed that the wallpaper needed to have been removed and the walls needed to have been painted.	F 584		

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F 584	Continued From page 5 *Agreed the register in the dining room could have been a hazard to the resident's and should have been fixed. Interview on 8/31/23 at 11:00 with administrator A and DON B revealed: *Maintenance director C showed them the wallpaper and screws before the interview. *They are waiting on a bid from a construction company to have the wallpaper removed and then paint the walls. *Agreed the heating register in dining room needed to have been fixed on the north wall of the dining room.	F 584		
F 600 SS=E	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, email communication review, and policy review, the provider failed to ensure: *A functional whirlpool tub was available to all	F 600	1. The whirlpool tub is in working order as of 9/22/23. All residents were interviewed regarding their bathing preferences and bathing schedules were updated on 9/14/23. 2. The DON or designee will provide education to all staff regarding bathing preferences and documentation by 10/6/23. Those not in attendance will be educated prior to their first shift worked. 3. The DON or designee will audit bathing documentation weekly x 3 months to ensure resident preferences are being met. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	10/6/23

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F 600	Continued From page 6 residents who preferred a tub bath. *Scheduled showers were offered and given to 16 of 40 sampled residents (3, 5, 6, 10, 12, 15, 17, 20, 23, 24, 25, 30, 32, 33, 38, and 40). Findings include: 1. Observation on 8/29/23 at 9:35 a.m. of the resident's shower room revealed: *A wheeled high-back chair was sitting against a wall and a handheld shower-head with a long hose was connected to the wall. -Bottles of shampoo, conditioner, and body wash were on top of the half-wall located next to the chair. *A whirlpool tub was in the corner covered with plastic. *There were no other whirlpool tub visible in the shower room. 2. Interview on 8/29/23 at 2:32 p.m. with maintenance director C regarding the non-functional whirlpool tub revealed: *They had a whirlpool tub, but it leaked, had draining and electrical issues. -He was not aware the last time it had been used. -They removed it from service two to three months ago. *The plastic-covered whirlpool tub was from another facility that they had received in July 2022. *He had not been able to get the whirlpool tub working for the residents due to having to have a new electrical outlet put in. *He had been calling the local electrician since October 2022 to have them come to the facility to work on the whirlpool tub. -The last time he talked to the local electrician was two months ago when they were at the facility fixing another electrical issue.	F 600		

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F 600	Continued From page 7 --The local electrician stated he would have to set a time but has not gotten back to him. 3. Observations and interviews on 8/29/23 between 9:37 a.m. and 3:29 p.m. revealed: *At 9:37 a.m. resident 6 was observed resting in bed with her eyes closed; her hair appeared greasy and unkempt. *At 9:51 a.m. during interview with resident 33 she shared, at times it has been three weeks between her showers. She would have preferred a shower once a week. *At 10:10 a.m. resident 30 was observed laying in bed watching TV; his hair appeared greasy and unkempt and there was an odor of urine present. -When asked, he was unable to recall his last shower. The staff were unable to offer a bath because the whirlpool tub was not working: *At 10:22 a.m. during interview with resident 25 he shared, he had been admitted 5/16/23, and it was over two weeks before he had received a shower after admission to the facility. He had never been offered a bath because the whirlpool tub was broken. There was a bathing schedule but had felt it was not followed. *At 10:57 a.m. during interview with resident 12 he shared; he was to have been given a shower every Friday. While sometimes he does refuse, he was not always asked if he would like a shower every Friday. *At 11:12 a.m. during interview with resident 40 he shared, it had been over a week since he had his last shower and had never refused a shower. *At 11:13 a.m. resident 3's husband was present when she was observed. She was sleeping in her recliner; her hair appeared greasy and unkempt. -When asked, he stated her last shower was a week ago. There was no functioning whirlpool tub to offer a resident a bath.	F 600		

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F 600	Continued From page 8 *At 1:23 p.m. resident 23 was observed her hair appeared greasy and unkempt and there was body odor present. -When asked she reported the staff were behind a few weeks giving resident showers. While there was documentation that she had been given a shower she stated she had not received a shower. *At 1:30 p.m. resident 10 was observed resting in bed with his eyes closed; his hair appeared greasy and unkempt. *At 2:18 p.m. resident 32 was observed; his hair appeared greasy and unkempt. *At 2:23 p.m. resident 15 was observed with greasy and unkempt hair. -When asked he reported it had been over a week since his last shower and he had never refused a shower. *At 2:45 p.m. resident 17 was observed with greasy and unkempt hair. *At 2:50 p.m. resident 24 was observed sitting on his bed; his hair appeared greasy and unkempt with body odor present. -He stated he was ton have a shower every two weeks and had never refused a shower. *At 2:56 p.m. resident 20 was observed his hair appeared greasy and unkempt; he was unshaven and there was body odor present. His eyeglasses were not clean. -When asked, he could not recall the last shower he had. *At 3:21 p.m. resident 5 was observed resting in bed; his hair appeared greasy and unkempt. -When asked, he had only been offered a shower and not a whirlpool tub bath due to no operational whirlpool tub for months. *At 3:29 p.m. resident 38 was observed with greasy and unkempt hair. -When asked, he stated it had been a week and a	F 600		

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F 600	Continued From page 9	F 600		

half since his last shower and he had never refused a shower.

4. Interview on 8/30/23 at 2:28 p.m. with regional director D regarding whirlpool tub revealed he:
*Had known that the maintenance director C had been attempting to get the local electrician to the facility.
*Had been calling electricians outside the local area to have them come to the facility to work on the whirlpool tub but they have all declined.
-Had last called an electrician two and a half months ago.

Interview on 8/31/23 at 10:54 a.m. with administrator A and director of nursing (DON) B regarding the non-functional whirlpool tub revealed they:
*Stated there has not been a working whirlpool tub since they had received the whirlpool tub from the other facility in July 2022.
-Stated the whirlpool tub they had was leaking and had electrical issues.
*Had known it was an issue getting an electrician into the facility to work on the whirlpool tub.
-Had known regional director D was assisting maintenance director C with trying to find an electrician.
*Were not aware that some of the residents would have preferred a whirlpool tub bath.

Interview on 8/31/23 at 10:58 a.m. with DON B revealed she:
*Stated the not offering of the shower could have been that the staff had not documented that the showers were done or if the residents had been out of the facility on the scheduled day of their shower.
*Stated staff were to offer a bed bath if the

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F 600	Continued From page 10 resident refused a shower or offer a different day to take a shower when a resident refused. *Had a bath aide but that the bath aide gets pulled to the floor often and the floor staff were then responsible for getting the resident's showers done for that day. -Had been attempting to get the floor staff to work together to complete the resident's showers for that day. *Stated it could have been the approach of the staff to the residents that caused the refusals but that had not been addressed with the staff. 5. Review of email communications from infection control nurse E to DON B and administrator A during period from 6/12/23 through 8/22/23 revealed the content reflected approximate one week of data in each email of resident shower refusals and those residents that had not been offered a shower . *On 6/12/23 at 10:15 p.m. email reflected 5 refusals and 5 not offered. *On 6/20/23 at 4:17 p.m. email reflected 6 refusals and 3 not offered. *On 6/26/23 at 10:22 a.m. email reflected 11 refusals and 4 not offered. *On 7/3/23 at 9:42 a.m. email reflected 3 refusals and 1 not offered. *On 7/10/23 at 10:36 a.m. email reflected 8 refusals and 1 not offered. *On 7/17/23 at 2:10 p.m. email reflected 4 refusals. *On 7/24/23 at 11:16 a.m. email reflected 5 refusals and 1 not offered. *On 8/2/23 at 9:56 p.m. email reflected 1 refusal and 1 not offered. *On 8/8/23 at 2:19 p.m. email reflected 2 refusals and 10 not offered. *On 8/14/23 at 3:06 p.m. email reflected 4	F 600		

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F 600	Continued From page 11 refusals and 10 not offered. *On 8/22/23 at 2:04 p.m. email reflected 13 refusals and 4 not offered. 6. Review of the provider's September 2019 bathing policy revealed: *Policy -"The resident has the right to choose timing and frequency of bathing activity. Bathing preferences are asked upon admission and during quarterly care conference."	F 600		

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 8/28/23 through 8/31/23. Avantara Redfield was found in compliance.	E 000		

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

Diane Forgey | Administrator | 9/22/23

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 ho es, 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
	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/29/23. Avantara Redfield Building 1 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to maintain egress doors as required at one randomly observed exit door location (staff EXIT from the dietary area). Findings include: 1. Observation on 8/29/23 at 10:15 a.m. revealed the exterior EXIT door was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed the door lock functioned	K 211		

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

Diane Forgey

TITLE

Administrator

(X6) DATE

9/22/23

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
	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(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
K 211	Continued From page 1 as a delayed egress lock. The required signage per LSC 7.2.1.6.1 was not in place. Interview with the director of maintenance at the time of the observation confirmed that finding. B. Based on observation and interview, the provider failed to provide egress doors as required at egress door locations (ACU and AACU). Findings include: 1. Observation and interview on 8/29/23 beginning at 11:00 a.m. revealed the Acute Care Unit (ACU) and Alzheimer's Acute Care Unit (AACU) cross-corridor doors had magnetic locks in place. Testing of the cross-corridor doors at the AACU from the ACU revealed the magnetic locks were active. The provider had removed memory care beds for the 7/1/21 license renewal. The magnetic door-locking arrangements for those two areas (ACU and AACU) needed to meet the LSC 7.2.1.6 Special Locking Arrangements for either Delayed-Egress Locking Systems or Access-Controlled Egress Door Assemblies at that time. Interview at the time of the observation with the director of maintenance confirmed those conditions. He stated he was a new employee after the memory care had been discontinued. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6	K 211	A. 1. Required signage was ordered for the staff EXIT from the dietary area on 9/14/23. 2. The Administrator or designee will provide education to all staff by 10/6/23. Those not in attendance will be educated prior to their first shift worked. 3. The Maintenance Director or designee will audit all doors with delayed egress for required signage monthly x 3. Results of audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations. B. 1. The magnetic locks were removed from doors on the previous ACU and AACU doors on 9/15/23. 2. The Administrator designee will provide education to all staff by 10/6/23. Those not in attendance will be educated prior to their first shift worked. 3. The Maintenance Director or designee will audit the previous ACU and AACU doors to ensure no magnetic locks are in place monthly x 3. Results of audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	4. 10/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(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
K 321	Continued From page 2	K 321	1. The opening in the laundry room ceiling was repaired with new insulated ceiling tiles to cover the opening on 9/14/23. 2. The Administrator or designee will provide education to all staff on maintaining separate hazardous areas with a smoke-tight enclosure by 10/6/23. Those not in attendance will be educated prior to their first shift worked. 3. The Administrator or designee will audit all separate hazardous areas with a smoke-tight enclosure monthly x 3 to ensure a smoke-tight enclosure. Results of audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	4. 10/6/23
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one randomly observed separate hazardous areas (laundry room) with a smoke-tight enclosure. Findings include:	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(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
K 321	Continued From page 3 1. Observation on 8/29/23 at 10:30 a.m. revealed the laundry room was over 100 square feet in area with large amounts of combustibles in the room. The ceiling had an opening approximately six square feet in area where insulated ceiling tiles were missing. Interview with the director of maintenance at the time of the observation confirmed that finding. The missing ceiling tile would negate the smoke-tight properties of the room. The ceiling opening would allow hot gases to migrate to the plenum area above the ceiling tile before the fire safety equipment would function as designed. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING **02 - BUILDING 02** B. WING _____	**08/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/29/23. Avantara Redfield Building 2 was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards..	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to provide egress doors as required at egress door locations (AACU). Findings include: 1. Observation on 8/29/23 beginning at 11:00 a.m. revealed the Alzheimer's Acute Care Unit (AACU) cross-corridor doors had magnetic locks in place. Testing of the cross-corridor doors at the AACU from the ACU revealed the magnetic locks were active. The provider had removed memory	K 211	1. The magnetic locks were removed from the doors on the previous ACU and AACU doors on 9/15/23. 2. The Administrator or designee will provide education to all staff by 10/6/23. Those not in attendance will be educated prior to their first shift worked. 3. The Maintenance Director or designee will audit the previous ACU and AACU doors to ensure no magnetic locks are in place monthly x 3. Results of audits will be presented by the Maintenance Director or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	4. 10/6/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Forgey	Administrator	9/2/23

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
	435054	A. BUILDING **02 - BUILDING 02** B. WING _____	**08/29/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(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
K 211	Continued From page 1 care beds for the 7/1/21 license renewal. The magnetic door locking arrangements for this area (AACU) needed to meet the LSC 7.2.1.6 Special Locking Arrangements for either Delayed-Egress Locking Systems or Access-Controlled Egress Door Assemblies at that time. Interview at the time of the observation with the director of maintenance confirmed those conditions. He stated he was a new employee since the memory care had been discontinued. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6	K 211		

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
	10671	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/28/23 through 8/31/23. Avantara Redfield was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/28/23 through 8/31/23. Avantara Redfield was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Forgey

TITLE: Administrator

(X6) DATE: 9/22/23