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
	435039	A. BUILDING _____ B. WING _____	C 04/06/2022

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

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F 000	INITIAL COMMENTS Surveyor: 32332 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/5/22 through 4/6/22. Areas surveyed included dietary services, quality of care, pharmacy services, nursing services, infection control, and abuse and neglect. Avantara Norton was found not in compliance with the following requirements: F684 and F755.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and record review, the provider failed to ensure: *Diets were followed as ordered resulting in a choking episode for one of one resident (4). *A care plan had been updated to identify goals and interventions to prevent further choking episodes for one of one resident (4). *A resident (4) was supervised for potential of choking during one of three observed meal services. *A process was in place for meal delivery to identify the correct diet for each resident who	F 684	Resident 4 has not had any repeated instances of choking since the single episode prompting this survey. Care plan has been reviewed and updated by the Register Dietitian (RD) to identify goals and interventions to prevent further choking episodes. Care plan was updated on 4/12/2022 to reflect SLP's recommendation for the resident's need to sit upright in wheelchair, caregiver assistance/supervision as needed with feeding, curing to take small bites and sips, encourage alternating liquids and solids, and oral care following meals. Care plan was reviewed for his dining room environment preferences. The resident is to be seated at an assisted table for increased supervision at mealtime. Resident may have his back to the dining room to minimize distractions so he can focus on eating. Resident is to be seated at an assisted table with a staff member, certified nursing assistant, assigned to for meal times. SLP was consulted for the most appropriate diet. SLP recommends that resident 4 diet be	5/5/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty
TITLE: LNHA
(X6) DATE: 4/29/2022

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 684	Continued From page 1 received their meals in the dining room. *A documentation process was in place to accurately capture meal and oral intake for residents. Findings include: 1. Review of the provider's online self-report to the SD DOH on 3/15/22 revealed: *On 3/14/22 resident 1 had a choking episode during the supper meal. *The resident was able to expel the food on his own and had not required outside treatment. *The resident had a piece of regular bread on his plate. *The resident had not been given the correct diet. *The resident had a diet order for a "regular diet, dysphagia [difficulty swallowing] mechanically altered (level 2) texture, thin liquids." *"Educated staff on duty on 3/15/22 at 10:00 a.m. need to look at diet card prior to serving trays, to ensure correct diets are being given, to all residents." A conclusionary summary to the provider's self-report had indicated: *Resident 4 had been evaluated by the speech therapist (ST) last on 7/22/21 and a NDD (National Dysphagia Diet) 2/IDDSI (International Dysphagia Diet Standardisation Initiative) 5 (a mechanical diet that altered the texture - chopped, very soft foods, ground meat, and minced/moist food. Breads were to have been pureed.) His liquids could remain thin. *The dietitian had audited all the diet textures on 3/15/22 and her audit indicated: -Resident 4 had a correct diet on the meal ticket (a diet card specific to what diet he was to have). --His care plan had not been updated with his current diet but had been updated on 3/15/22.	F 684	NDD1 or IDDSI 4 and this recommendation is being followed. Administrator, DON, and interdisciplinary team in collaboration with the Medical Director have reviewed the process for meal delivery to identify the ordered diet for each resident has been clarified, meal documentation process, care plan policy to ensure that goals and interventions are developed and implemented based on resident's current condition and communication with staff regarding changes in a resident's cognition in regard to dietary needs. Meal delivery education completed with all staff to ensure meal tray tickets were are taken to the table when serving residents on 5/5/2022. Interdisciplinary team and RD review of all residents in need of assistance, cueing, and supervision are currently reviewed weekly at the Interdisciplinary Nutrition at Risk meeting and updates care plans as needed. Nutrition Binder will be updated every Tuesday after Nutrition at Risk meeting with RD, with an additional binder put on Warren Wing for certified nursing assistant that is serving on Warren. Ipads were purchased for the dietary staff to document meal intakes. Ipad PCC training was provided to dietary staff on 5/3/2022. RD also provided education on how to determine meal intakes. Dietary staff will document all dining room meals. Nursing staff who picks up room trays,	

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F 684	Continued From page 2 -All other residents with altered textures had matching diet and care plan on their meal ticket and care plan. *The dietitian was to have provided mandatory education on diets for all staff on 3/24/22. *A binder had been placed at the serving window in the kitchen for all staff to reference. "It lists all current residents, diets, textures, thickened fluids, supplements, serving sized and descriptions of what the meals should look like. This binder will be updated every Tuesday and the nutrition risk meeting. Staff are being provided education on the binder at the beginning of each meal service and additional education be provided at the all staff on 3/24/22 by DON [director of nursing]." Review of the 3/14/22 at 8:11 p.m. interdisciplinary progress note by licensed practical nurse (LPN) I revealed: *Resident 4 had a choking episode at the evening meal. *The kitchen aide had noticed the resident with his head laid back in his wheelchair and trying to clear his throat. She leaned him forward and he began to clear his throat. *LPN I was summoned to the dining room to assist and noted a regular piece of bread on his plate. *Resident 4 was not given the correct diet. *"The kitchen staff and CNA's [certified nursing assistants] were counseled to ensure correct diet is given." *He was taken to the nurses station and monitored. Observation of the noon meal on 4/5/22 at 12:00 p.m. revealed: *Dietary manager F was plating food and handing the plate to a CNA to deliver to the residents.	F 684	will be responsible for documenting those meals. Meal extension competencies will be completed on all dietary, nursing, and activity staff by 5/5/2022 by RD or designee. RD or designee will educate all staff by 5/5/2022 on the process for ensuring each resident receives their ordered diet and diet descriptions. RD or designee will educate all dietary and nursing staff on meal documentation to include visual estimation guides and competencies. RD or designee will educate all staff on the International Dysphagia Diet Standardization Initiative and where this information can be accessed. DON or designee will educate all staff on the roles and responsibilities for assisting residents at risk for choking and dependent on staff for assistance. All education will be completed by 5/5/2022 or before their next scheduled shift if they are unable to attend the training. RD or designee will audit the master diet list weekly x4 weeks, the monthly x3 months. RD or designee will audit 5 residents per week for accurate diet order, dietary care plan, and meal ticket accuracy. These audits will be weekly x4 weeks, then monthly x3 months. A mealtime audits tool, which will audit quality of life, nutrition, and safety at meal times, will be completed by department managers for all three meals per day 7 days a week for 2 weeks. Audit	

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F 684	Continued From page 3 *The CNA would pick up the plate and place the meal ticket upside down in a pile of meal tickets. -That CNA would then take the plate to a resident in the dining room and set it down in front of the resident. *There were no binders at the serving window for staff to review as stated in the provider's self-report. *Dietary manager F had picked up a black binder from the kitchen table behind him one time and then placed it behind him again. Interview on 4/5/22 at 12:15 p.m. with registered dietitian (RD) D regarding resident 4's choking episode on 3/14/22. RD D stated: *The kitchen staff have had a large staff turnover over the last several months. *The provider has had difficulty maintaining a dietary manager. *The previous dietary manager had resigned and she did not think the new dietary manager F had started working. *On the day of the choking episode the person cooking and dishing up plates had been a temporary CNA. *RD D stated there had been times there were no cooks to fill empty slots. *The DON and others filled in when there was no cook. *On the day of the choking episode CNA J's focus was making sure every resident had food. -The focus was not on diets. *The current dietary manager had no experience in healthcare when he started but he was learning the diets. *When asked about the meal tickets RD D stated the provider stopped placing each resident's meal on the ticket because residents became upset when they were not served what was on the	F 684	will then taper to 2 meals per day, then 1 per day based on outcomes of the audit and recommendations from QAPI committee. Mealtime documentation completion audit will be completed daily by the Administrator or designee daily x2 weeks, 3 times a week x2 weeks, then one time per week x2 months. RD, Administrator, and designees will bring audit results to QAPI for results, review, and recommendations.	

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F 684	Continued From page 4 ticket. -The staff did not want to bring the meal ticket to the table because the residents became upset. -The fill-in staff had chosen easy foods to cook rather than follow the menu. -She confirmed the provider now had the menu on their meal ticket with the diet to be served and the amount and type of food to be served. -She was not sure why the ticket was not brought to each resident to confirm accuracy of the diet. *When asked about the binder for staff to reference she stated all questions about the binder needed to go to the DON because she was the one to put the binder together. "I had nothing to do with that." *When asked if the binder was for the cooks or the CNA servers she stated it was probably for the cooks. Observation on 4/6/22 at 8:25 to 9:00 a.m. of the center dining room revealed: *Resident 4 was sitting in a wheelchair facing the far west wall. -He had slid down in the chair and held an empty glass of water. No food or other drinks had been present. He was the only resident at the table. *CNA E sat on the east wall with three other residents who were receiving supervision or assistance. *CNA E would not have been able to see resident 4's face from where she was sitting. *This surveyor approached resident 4 and asked if he had already eaten. *The resident stated he had not and wondered if he was going to get breakfast. *This surveyor approached CNA E asked and if resident 4 could get his breakfast. -CNA E approached cook G and asked about his breakfast:	F 684		

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F 684	Continued From page 5 *Cook G placed corned beef hash and scrambled eggs on a plate (that was part of his mechanical soft diet). *CNA E told the cook the resident was at risk for choking. *Cook G dished up two bowls of oatmeal and this was brought to the table. *A meal ticket had not been brought to the resident's table. *CNA E returned to the residents across the room and resident 4 sat alone facing the wall, and holding the oatmeal bowl to his chest to eat. He remained slightly slumped down in the wheelchair. *This surveyor questioned CNA E about resident 4's need for assistance with his meal. She stated: -He was capable of feeding himself. -He did not allow staff to feed him. -There were no available staff to sit with him. -She could see him from across the room. -She did not know why he was not given the plate of food that was dished up for him. *CNA E then sat with resident 4 and supervised him. Further interview with CNA E regarding resident 4 and the dining process revealed: *The CNAs did not bring meal tickets to the residents with their meal. *Only those residents who received meals eaten in their room received the meal tickets. *When asked about documenting the meal intakes after each meal she stated: -CNAs were supposed to document the meals of the residents down the halls they were assigned to but they did not come to the dining room to check their intakes because they were busy cleaning, removing garbage, and making beds on the unit.	F 684		

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Interview on 4/6/22 at 9:00 a.m. with cook G revealed:
*He did not know why resident 4's plate of food had not been given.
*When asked what happened to the meal tickets after he dished up the residents' food he stated:
-He threw them away.
-Confirmed the meal tickets had an area to document meal intakes, but they had not been filled out.
-He was not sure who was supposed to document the meal intakes.
*When asked about a binder that was supposed to have been placed at the serving window, he brought this surveyor a menu book.

Interview on 4/6/22 at 12:25 through 1:10 p.m. with assistant dietary manager H revealed:
*She had:
-Been an employee for approximately one year.
-Worked as the dietary manager for approximately two months.
*On the day of resident 4's choking event he had been served a french dip sandwich on regular bread.
-The diets were not followed.
*The binder:
-Was supposed to be kept on the serving window.
-Had been developed for the CNA's to refer to regarding each residents diet order and what foods were allowed and not allowed in each diet order.
*The cooks were to have referred to the diet menu book for information.
*The CNA's were supposed to bring the residents' meal tickets to their tables with their food to make sure the meal and diet were correct.
*She did not know who was supposed to be

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documenting meal intakes.
*The dietitian had updated the CNA binder on 4/5/22 and it was to be updated weekly with dietary orders for the residents.
*She was not sure who was to have updated the dietary care plans.

Review of resident 4's medical record revealed:
*A current order summary indicated:
-A 7/22/21 diet order for: 'Regular diet, dysphagia [difficulty swallowing] mechanically altered (level 2) texture, thin liquids consistency."
-A 3/16/22 order for ST to evaluate and treat.
*A previous 5/18/21 therapy note by speech language pathology (SLP) K for a swallowing screen referral indicated resident 4 had been found cheeking "10+ peanuts in mouth over the weekend. Pt [patient] unable to chew." Resident 4 refused to participate in an assessment. SLP K recommended the use of universal swallow precautions for decreased pocketing episodes:
-To sit upright in his wheelchair for all oral intake.
-Cueing to eat and swallow at a slow rate.
-Cueing to take small bites and sips.
-Encouraging alternating liquids and solids.
-Assessing the oral cavity following oral intake to ensure his mouth had been cleared.
-Oral care following meals.
*A 7/22/21 SLP K evaluation provided recommendations for:
-IDDSI 5/0 thin liquids (minced moist foods with thin liquids).
-Oral care following all meals.
-Caregiver assistance/supervision as needed with feeding. The SLP indicated he required supervision/assistance due to significant history of food pocketing twenty-six to forty-nine percent of the time.
-Caregivers were to provide cueing for using

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small bites, slow rate of intake, alteration of foods and liquids, and use of a mouth sweep to monitor for clearing food.
-There was a diagnosis of dysphagia, oral phase.

Dietitian notes had been requested from the DON on 4/6/22. This surveyor received only a 1/11/22 Dietary Evaluation. That evaluation indicated his diet:
-Was a concentrated carbohydrate diet with regular consistency and thin liquids.
-The resident did not have functional problems that affect his ability to eat.
-He had no behavioral problems.
-He was independent with set-up and eating.

Review of resident 4's revised 4/1/22 care plan related to his swallowing problems and choking event revealed:
*He had dementia which resulted in the need for an altered texture diet due to swallowing problems related to dementia progression. -A 12/6/19 Activities of Daily Living (ADL) care plan indicated he required assistance with eating.
*The goal was that he would not experience weight changes.
*He could choose his own food choices at meal and snack times.
*There were no interventions on the care plan to guide the staff for prevention of safe eating as recommended by the SLP.

Interview on 4/6/22 at 2:20 p.m. with DON B and occupational therapist registered (OTR)/director of rehabilitation (DOR) L and regional nurse consultant C revealed:
*Resident 4 had a 3/16/22 order for speech therapy but it was decided that the choking episode was not a resident problem but a staff

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issue due to the resident receiving the wrong diet.
-He will be receiving SLP therapy to work on communication due to his verbal outbursts including at mealtime.
*They:
-Stated the previous SLP recommendations for assisting the resident with eating safely were just universal guidelines and not specific for the resident.
-Confirmed:
--Those guidelines had not been added to his care plan.
--The care plan was not specific and did not address interventions to prevent choking.
--Education was provided for use of the binder for the aides to use, but had not been utilized by the staff.
*Regarding the lack of consistent meal intake documentation the DON stated before the pandemic the dietary aides were documenting the meals but that had stopped when residents were not eating in the dining rooms.
-The provider planned to have the dietary aides document intakes again.
*Regarding dietitian evaluations for resident 4 the DON stated she was unable to locate further documentation.
*Head of therapy L stated resident 4 could be observed for choking from across the room.
*Nurse consultant confirmed:
-The meal tickets should have been brought to each resident during meals to monitor for correct diets.
-The diets had not been followed on 3/14/22, but should have been followed.

Review of the provider's September 2019 clinical management policy revealed:
*Care planning was to have been constantly in

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F 684	Continued From page 10 process. *The physicians' orders in conjunction with the care plans constitute the total plan of care. *The DON would be responsible for holding the team accountable to initiating and updating the care plan. *Each staff member working with the individual resident is responsible to read, utilize, and offer input to improve the care plan. *Care plans were to have been updated between care conferences as changes occur. Requests for policies regarding safe feeding, monitoring for choking, documentation of oral intakes, and the use of the new binder protocol had been made to the DON. No policies had been provided.	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755	No immediate correction could be made for residents 1, 2, or 3. All residents are at risk for not receiving routine and/or emergency drugs and biologicals. Process of acccounts for and documenting disposition of all medications was initiated on 4/26/2022. Pharmacist consulted on 4/28/22 for auditing and processes. All LPN, RN, and Medication Aide staff will be educated on this process at the mandatory nursing meeting on 4/28/2022 by DON. This process has been added to the new hire and annual education that is provided to all RN, LPN, and medication aide staff with education provided by DON or designee. RN, LPN, and	5/5/2022

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F 755	Continued From page 11 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on interview, record review, and policy review the provider failed to ensure medication destruction and accountability had been properly completed by one registered nurse (RN) and a witness to prevent diversion for: *Two of two closed sampled resident records (1 and 2). *One of one current sampled resident record (3). Findings include: Review of report submitted by the provider to the SD Department of Health on 4/1/22 at 11:06 a.m. revealed this investigation. Findings include: *The facility had not been aware of any medication improperly removed from the facility until a detective arrived on 3/14/22. *The following medication had been in possession of licensed practical nurse (LPN) D. *Medication belonging to resident 1 included: -Duloxetine 60 mg: 21 capsules remaining out of a 30 in the blister pack. *Medication belonging to resident 2 included: -Seroquel 25 mg. None remaining in the blister	F 755	medication aide staff will be educated that DON and nurse managers will have access to medications after they are discontinued and placed into security bin by charge nurse or nurse manager. Once discontinued, medications are to be immediately pulled from the medication cart, counted by two staff members, and placed into bin. Medications will be recounted once obtained by DON or nurse manager before destruction or sent back to pharmacy as needed. Destruction will take place twice weekly by DON or designee. Facility has adopted pharmacy providers policy for medication security. DON or designee will audit 3 discontinued medications weekly x4 months for appropriate documentation and disposition of all medications. Results of the audits will be reported at the monthly QAPI meeting. Continued audits will be per the discretion of the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 12 pack. *Medication belonging to resident 3 included: -Levothyroxine 50 mcg: 11 remaining out of 30 in the blister packs. *Gabapentin 600 mg: 6 remaining out of a unknown amount. Interview on 4/5/22 at 3:30 p.m. with director of nursing (DON) B revealed: *Discontinued medication provided by PharMerica Pharmacy were scanned and returned to the pharmacy. *They did not keep a log count of discontinued/returned medication to PharMerica pharmacy. *They had been keeping a log count of discontinued/returned medication since 3/14/22. *Medication that were not provided by PharMerica are logged and counted and destroyed upon discontinuation. -Those log sheets are scanned into the resident's medical record. *The facility does not keep a copy of any log sheets for medication that had been returned to PharMerica. *If DON B was not working at the time of discontinuation of any medication, the medication would be kept in the medication cart until she removed it. *She had been trying to remove discontinued medication and destroy medication every day. *She had been doing this since October 2021. Interview on 4/5/22 at 3:40 p.m. with regional nurse consultant C revealed: *She had conducted the investigation for the diverted medication. *She had provided information from PharMerica manifests of medication dispensed to the	F 755		

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F 755	Continued From page 13 provider. Interview on 4/6/22 at 7:45 a.m. with DON B regarding logs for destroyed medication revealed she: *Did not have a log for medication that were returned to PharMerica or destroyed prior to 3/14/22. *Stated that PharMerica had been keeping track of that. *Stated the provider received a daily audit of medication administered and medication count. Interview on 4/6/22 at 12:45 p.m. with regional nurse consultant C regarding her investigation report revealed: *Her report was submitted to the SD Department of Health. *Staff had been made aware of the investigation. Review of policy for Disposal of Medication by PharMerica dated 2007 utilized by the provider revealed: *A non-controlled medication disposition log or form shall be used for documentation and shall be retained as per federal privacy and state regulations. The log would contain: *Resident's name, medication name and strength, prescription number, quantity/amount disposed, date of disposition, signatures of required witnesses. *DON B stated they did not use that policy since there was no regulation for non-controlled medication.	F 755		