

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

PRINTED: 02/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/05/2022
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NAME OF PROVIDER OR SUPPLIER AVANTARA ARMOUR	STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK ARMOUR, SD 57313
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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/4/22 through 1/5/22. Avantara Armour was found in compliance.	E 000		
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/4/22 through 1/5/22. Avantara Armour was found not in compliance with the following requirement(s): F578, F684, F755, and F880.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578	1. Resident 12's advanced directives were reviewed with the resident's power of attorney (POA) and she stated she wants to continue his current status of DNR during pandemic on 1/14/22. Status will be reviewed quarterly during care conference meetings and will have provider review on 60-day visits. Resident	1/29/22

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

Kassia Doty

TITLE

LNHA

(X6) DATE

02/02/2022

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 578	<p>Continued From page 1</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and policy review, the provider failed to update advanced directives for two of fourteen sampled residents (12 and 122). Findings include:</p> <p>1. Review of resident 12's electronic medical record (EMR) revealed:</p> <p>*He had been admitted on 1/17/19.</p> <p>*An undated full code status had been signed by</p>	F 578	<p>122's advanced directives was obtained and filed on 1/5/22.</p> <p>2. All residents have the potential to be affected by not having advanced directives updated. All residents advanced directives have been reviewed, updated, documented and filed in the residents' charts as of 1/26/22.</p> <p>3. Social Service Designee G and the Interdisciplinary team (IDT) were educated on 1/18/22 by RNC C regarding advanced directives. The policy, federal regulation, and the advanced directive form were reviewed during this education.</p> <p>4. The Director of Nursing (DON)/ designee will audit 5 random resident charts to ensure the advanced directives are current, up to date, documented and filed weekly for 4 weeks, biweekly for 1 month, and monthly for 4 months. The DON/designee will audit care conference notes quarterly for 1 year to ensure advanced directives are being reviewed during care conference meetings.</p>	

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F 578	<p>Continued From page 2</p> <p>resident 12's power of attorney.</p> <p>*On 4/24/20 an order was received for resident 12 for "DNR [do not resuscitate] during the COVID pandemic and then return to FULL CODE [resuscitation procedures performed] status."</p> <p>*Had not been any updates since 4/24/20.</p> <p>2. Review of resident 122's EMR revealed:</p> <p>*She had been admitted on 11/8/21.</p> <p>*The EMR did not have a code status.</p> <p>*There was no physician order for her code status.</p> <p>Interview on 1/5/22 at 2:54 p.m. with social service designee G revealed:</p> <p>*She was responsible for completing resident admission paperwork.</p> <p>-This included completing the forms with the resident regarding advanced directives and code status.</p> <p>*The admitting nurse, medical records, or social services sent the code status request form to the resident's physician for review and signature.</p> <p>*She agreed the advanced directives and code status for resident 122 had not been completed.</p> <p>*She was not at work in the facility on 11/8/21.</p> <p>-Administrator A had completed the admission paperwork for resident 122.</p> <p>*She was unsure why the resident's advanced directives and code status forms had not been completed.</p> <p>Interview on 1/5/22 at 3:21 p.m. with administrator A, interim director of nursing B, and regional nurse consultant C revealed:</p> <p>*A DNR order had been obtained during a COVID outbreak per the direction of the medical director.</p> <p>*They agreed the order was confusing and unclear.</p>	F 578	<p>Results of audits will be discussed by the DON/designee at the Quality Assessment Process Improvement (QAPI) meetings with the IDT and medical director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.</p>		

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F 578	Continued From page 3 *Resident 12's Code status had not been reviewed since 4/20/20. *They agreed a discontinue or stop date should have been specified. *Administrator A had completed the admission paperwork for resident 122 on 11/8/21. -She agreed the advanced directives and code status had not been completed. Review of provider's September 2019 Advanced Directive Policy revealed the resident's Advanced Directive choices/options shall be reviewed with resident/representative during quarterly and significant change assessment and care planning.	F 578		
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: Based on observation, interview, and record review, the provider failed to ensure one of fourteen sampled residents (10) received the necessary care and services to: *Ensure when complaining of severe pain he received his prescribed pain medications in a timely manner. *Ensure he received social services assistances in sorting out care situation when he was	F 684	1. Resident 10's medication orders were reviewed, medications have been given timely, Social Service assistant is working with resident to provide Leisure Counseling services via telehealth. We are currently awaiting the return of their paperwork to set up his evaluation. A Level-o-gauge has been put on his bed to quickly and easily ensure resident HOB is elevated at 30 degrees or greater. Feeding tube placement has been verified before administration of medication and he is being checked every two hours to to ensure he is being toileted.	1/29/22

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F 684	<p>Continued From page 4</p> <p>exhibiting behaviors in December 2021.</p> <p>*Ensure the head of his bed was positioned at least 30 degrees to try to prevent complications related to continuous tube feedings.</p> <p>*Ensure feeding tube placement had been verified before administering medication.</p> <p>*Ensure staff had assisted him with his toileting needs.</p> <p>Findings include:</p> <p>Surveyor 45383:</p> <p>1. Observation and interview on 1/5/21 at 8:36 a.m. with resident 10 and certified nursing assistant (CNA) H revealed:</p> <p>*He was asking for his pain medication.</p> <p>*CNA H informed the resident that the nurse would give him his medication at 9:00 a.m.</p> <p>Interview on 1/5/21 at 8:48 a.m. with licensed practical nurse (LPN) F regarding resident 10's pain medication revealed the last time he had received his as needed [prn] pain medication was the day before on 1/4/22 at 1:21 a.m.</p> <p>Surveyor 42477:</p> <p>2. Ongoing observations and interview on 1/5/21 between 9:05 a.m. and 9:16 a.m. with LPN F, resident 10, and interim director of nursing (DON) B revealed:</p> <p>*At 9:05 a.m., resident 10 asked LPN F if he could have his pain medication.</p> <p>-She voiced she would give them to him "shortly" between 9 and 10 a.m.</p> <p>*At 9:09 a.m., this surveyor was in the hallway, outside his room and could hear him yelling out in loud moans.</p> <p>*At 9:12 a.m., this surveyor was down the hallway and could hear resident 10 still moaning loudly and was able to be heard down the hallway,</p>	F 684	<p>Kardex, tasks, care plan, progress notes, and documentation has been completed daily as needed since 1/10/22.</p> <p>2. All other residents with pain, social service psychiatric issues, tube feeding, and toileting are at risk for not having pain medications administered timely, not receiving services assistance or timely follow up from the social service designee regarding a psychiatric episode, feeding tube placement verified prior to medications being administered, and assistance with toileting needs.</p> <p>3. RNC C and Administrator conducted the below education on the dates stated for the following staff: LPN F was educated on 1/5/22 regarding administering pain medication to Resident 10 in a timely manner, pain rating is resident specific and needs to be taken at the resident value and request for pain and to administer promptly upon request. RN K was educated on 1/6/22 regarding elevation of the bed</p>		

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F 684	<p>Continued From page 5</p> <p>interim DON B asked LPN F to give him his morphine dose because it would "work quickly." *Continued observation at 9:13 a.m. with resident 10 still yelling in pain, LPN F starting to get his vitamins out of the medication cart. -This surveyor inquired if she was going to administer his pain medications. -LPN F stated, "Yeah, well, I have this other med [medication] sitting here." --She placed the vitamin back and started to get his morphine out of the cart. *Continued observation at 9:16 a.m. of resident 10 and LPN F revealed: -Resident 10 told LPN F he was having "excruciating pain" and rated his pain as a 9 out of 10, with 10 being the worst. --LPN F administered his morphine into his mouth.</p> <p>Observation and interview on 1/5/21 at 9:32 a.m. with LPN F administering resident 10's other medications via his percutaneous endoscopic gastrostomy (PEG) tube revealed: . *She had not checked the placement of the PEG tube prior to administering his medications. *When surveyor asked if she usually checked placement, she stated: -"Only once per shift" and she had "already checked placement at 6:30 this morning."</p> <p>Surveyor 45383: 3. Observation of resident 10 on the following dates and times revealed he was lying in bed with his tube feeding infusing and the head of his bed [HOB] not elevated to a 30 degree angle. *On 1/4/22 at 7:30 a.m. *On 1/4/22 at 11:00 a.m. *On 1/5/22 at 10:00 a.m. *On 1/5/22 at 2:00 p.m.</p>	F 684	<p>and instructed on how to use the protractor, on 1/24/22 RN K was educated on the new level-o-gauge that is attached to Resident 10's bed and shows the elevation. The gauge will stay adhered to the bed. LPN F was educated on 1/6/22 of the importance of checking tube placement and accurately measuring resident medications per hysician order, a competency was completed on 1/27/22. CNA L and CNA J were educated on 1/24/22 regarding assisting Resident 10 with toileting needs at a minimum of every 2 hours. Social Service Designee G was educated on 1/21/22 by RNC C regarding importance of following up with Resident 10 for a psychiatric evaluation. All nurses and CNA's have been educated on pain management, Importance of elevating the HOB or all residents when receiving tube feeding and making sure HOB is 30 degrees or greater after performing personal cares by RNC C as of 1/29/22.</p>		

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F 684	<p>Continued From page 6</p> <p>Observation and interview on 1/4/22 at 8:43 a.m. with registered nurse (RN) K regarding the HOB elevation for tube feeding for resident 10 revealed: *He received continuous feeding via his PEG tube at 65 cubic centimeter (cc) per hour. *He had a sign above his bed which stated to keep HOB elevated to at least 30 degrees. *She had not been shown how to measure for HOB elevation. *She was not sure if his bed was at least 30 degrees elevated.</p> <p>Interview on 1/4/22 at 9:00 a.m. with resident 10 regarding tube feeding revealed: *He stated he started coughing when HOB was not elevated. *Staff would lay him flat when changing his brief. *Staff had not always remembered to elevate the HOB after laying him flat.</p> <p>4. Observation on 1/4/22 at 11:40 a.m. of personal cares with resident 10 performed by CNA L and CNA J revealed his perineal area was very red and irritated. Refer to F880, finding 4.</p> <p>5. Interview on 1/5/22 at 11:30 a.m. with resident 10 revealed: *He stated: -"Staff want me to suffer." -"That's why they don't give me pain medication." -"I have a lot of pain." -"Staff don't give me my pain medication." -"Wishes I had a knife to kill myself."</p> <p>Review of resident 10's social services documentation revealed: *On 12/2/21:</p>	F 684	<p>All nurses have received education and reviewed the Enteral feeding policy, Medication via tube feeding prior to or on 1/29/22 by RNC C. All CNA's have been educated regarding assisting residents with toileting needs in a timely manner to help with preventing skin irritation or breakdown by RNC C. All staff that were not working or present for the education will be educated prior to next shift worked.</p> <p>4. The DON/designee will audit the above Quality of Care areas to ensure all residents are receiving proper care and treatment. SSD and DON or designee will audit all residents with depression or thoughts of self harm.</p> <p>Areas will be audited weekly for 4 weeks, bi-weekly for 1 month, and monthly for 4 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting with the IDT and medical director for analysis and recommendation for</p>		

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F 684	<p>Continued From page 7</p> <p>-The interdisciplinary team was checking to see if he would qualify for a psychiatric evaluation, because he has had some behaviors.</p> <p>*There was no further documentation regarding follow up of a psychiatric evaluation or any notes passed 12/2/21.</p> <p>Review of resident 10's toileting records revealed:</p> <p>*He was dependent on staff for assistance.</p> <p>*The last documentation of his toileting was:</p> <p>-2:08 a.m. for changing his brief.</p> <p>-4:45 a.m. for having a bowel movement.</p> <p>*During a 30 day look back period he had not been toileted every two hours.</p> <p>On 1/5/22 at 11:45 a.m. this surveyor informed Interim DON B of resident 10's statements about harming himself and his complaints of pain and lack of pain management.</p> <p>Interview on 1/5/22 at 3:21 p.m. with Administrator A, Regional Nurse Consultant C, and Interim DON B revealed:</p> <p>*They had no way of measuring resident's bed to ensure HOB was elevated to at least 30 degrees.</p> <p>*PEG tube placement is to be verified prior to administering medications.</p> <p>*Resident 10's pain should have been addressed as soon as possible.</p> <p>*They were unable to find any involvement from regional social services consultant I since August 2021.</p> <p>*They had not seen any further follow up from social service designee G.</p> <p>*Staff are expected to toilet residents every two hours.</p> <p>Review of the provider's December 2019 Pain Management policy revealed:</p>	F 684	continuation/discontinuation/ revision of audits based on audit findings.	

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F 684	Continued From page 8 <p>"The pain management program is based on a facility-wide commitment to resident comfort." "'Pain Management' is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals." "Pain management is a multidisciplinary care process that includes the following:" -"a. Assessing the potential for pain;" -"b. Effectively recognizing the presence of pain;" -"c. Identifying the characteristics of pain;" -"d. Addressing the underlying cause of the pain;" -"e. Developing and implementing approaches to pain management;" -"f. Identifying and using specific strategies for different levels and sources of pain;" -"g. Monitoring for the effectiveness of interventions; and" -"h. Modifying approaches as necessary." "It is important to recognize cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain..." "Assess the resident's pain and consequences of pain for at least each shift." "'Possible Behavioral Signs of Pain:" -"a. Verbal expressions such as groaning, crying, screaming." -"b. Facial expressions such as grimacing, frowning, clenching of the jaw, etc." -"c. Changes in gait, skin color and vital signs;" -"d. Behavior such as resisting care, irritability, depression, decreased participation in usual activities." -"e. Limitations in his or her level of activity due to the presence of pain;" -"f. Guarding, rubbing or favoring a particular part of the body;" -"g. Difficulty eating or loss of appetite;"</p>	F 684		

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F 684	Continued From page 9 -"h. Insomnia; and" -"i. Evidence of depression, anxiety, fear or hopelessness."	F 684		
F 755 SS=E	<p>Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§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.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§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</p>	F 755	<p>1. Resident 10's Liquid Morphine was destroyed on 1/6/22 by Interim DON B and RNC C, a new bottle was opened to ensure the accurate amount of Morphine was in the bottle. On 1/11/22 the facility obtained prefilled syringes and an order to increase his Morphine to 0.5 ml, syringe count has been accurate during narcotic count. The bottle of Liquid Morphine was destroyed at no cost to the resident. Resident 10 has adequate supply of fiber source feeding. Water flushes are being measured accurately and administered per physician order. esident 5 has all ordered over the counter and prescribed medications available.</p> <p>2. Liquid Morphine bottles are at risk for being inaccurately recorded, all residents are at risk for not having their over the counter and prescribed medications related to supply not being reordered timely to ensure they have medications available</p>	1/29/22

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F 755	Continued From page 10 by: Based on observation, interview, record review, review of South Dakota Department of Health (SD DOH) complaint information, and policy review the provider failed to ensure: *One of two resident (10)'s Liquid morphine had been accurately counted and monitored in one of one medication carts. *Medications supplies were adequate to prevent two of two sampled residents (5 and 10) from running out of medications. *Accurate amounts of water had been given to one of one sampled residents (10) who had received his medications via his percutaneous endoscopic gastrostomy (PEG) tube. Findings include: 1. Observation and interview on 1/4/22 at 11:35 a.m. with registered nurse (RN) N revealed: *She was verifying narcotic counts with the surveyor. *Resident 10 had a bottle of liquid morphine. *RN N stated the narcotic log stated there should have been 7 milliliters (mLs) in the bottle. *She: -Agreed that it appeared to be around 4 mLs in the bottle. -Stated that she informed interim director of nursing (DON) B the count was off this morning. -Stated she signed that the count was correct at 7 mLs when it was actually at 4 mLs. -Mentioned the medication was hard to account for but agreed the bottles are always overfilled when they arrive. -Stated they mark the original count at 30 mLs when it is usually around 33 to 35 mLs. *Surveyor and RN poured liquid morphine into a medication cup to get an accurate measurement. -There was 3 mLs of liquid morphine when	F 755	when needed. All tube feeding residents are at risk for not receiving the appropriate amount of water flush during medication pass and not having placement of peg tube checked prior to administering water flush as detailed in F684. RN N was educated on 1/6/22 by RNC C on the importance of accurate narcotic count and to notify DON immediately upon first realization of when narcotic count is not correct. Interim DON B was educated that narcotic count discrepancy is an immediate medication investigation and to notify RNC C, pharmacy, and department of health. Incident/ investigation was submitted and accepted by DOH on 1/6/22. CMA O was educated by RNC C on 1/27/22 that if she discovers there is a medication unavailable she needs to report to the DON immediately so that pharmacy can be contacted to STAT the medication to the facility. If it is a stock medication facility will run to the local pharmacy or grocery store to obtain the over-the-	

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F 755	<p>Continued From page 11 poured into a medication cup. *The last morphine dose had been given on 1/4/22 at 1:21 a.m.</p> <p>Interview on 1/4/22 at 12:19 p.m. with interim DON B regarding the missing morphine revealed she: *Had noticed the morphine looked off about a week prior. *Stated now the count is "really off." *Was going to start an investigation into the missing liquid morphine. *Acknowledged staff had been signing off that the count was correct when it was incorrect.</p> <p>Review of resident 10's liquid morphine orders revealed he could receive 0.25 mL of liquid morphine every four hours as needed for pain.</p> <p>Review of the provider's liquid morphine reconciliation logs for resident 10 revealed the count had always been marked as "ok."</p> <p>Review of SD DOH complaint information revealed there had been some instances of the provider running out of residents' medications.</p> <p>Interview on 1/5/22 at 7:55 a.m. with certified medication aide (CMA) O revealed they often ran out of medications.</p> <p>2. Review of resident 5's electronic medical record (EMR) revealed she: *Had not received MiraLax for 6 days because the provider ran out. *Had not received 43 doses of her orthostatic hypotension medication due to it being "on order" from the pharmacy. -After a couple of weeks, a medication review</p>	F 755	<p>counter medication. LPN F was immediately educated verbally on 1/5/22 by Interim DON B regarding importance of checking placement of the peg tube prior to administering water flush or medications, she was also educated of the importance of properly measuring liquids and administering the correct amount of water before, between, and after medications. LPN F completed a medication pass via tube feeding competency on 1/27/22. All nurses will be educated regarding narcotic count, medication unavailable process, review the medication pass via tube feeding competency policy and Enteral feeding policy by 1/29/22.</p> <p>4. The DON/designee will audit narcotic count 5 times a week on random occasions for 1 month, biweekly for 1 month, and monthly for 4 months to ensure that liquid narcotics have the appropriate amount of liquid in the bottle. The DON/designee will audit the stock medication supply weekly for 1 month,</p>		

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F 755	<p>Continued From page 12</p> <p>was completed and she was taken off her orthostatic hypotension medication.</p> <p>Review of resident 10's EMR revealed he:</p> <ul style="list-style-type: none"> *Received his nutrition and hydration via his PEG tube. *Had run out of his fiber source feeding medication. -The provider had to supplement his feeding source until the new supply arrived. *Missed a dose of his antibiotics due to not having enough left in the bottle. <p>3. Observation and interview on 1/5/22 at 9:32 a.m. with licensed practical nurse (LPN) F revealed she:</p> <ul style="list-style-type: none"> *Had been administering resident 10's medications via his PEG tube. *Stated he had an order to receive: <ul style="list-style-type: none"> -30 cubic centimeter (cc) flush before and after medication administration. -10 cc flush between each of his medications. *Had not checked placement of his PEG tube prior to administration. Refer to F684, finding 2. *Flushed each of his medications with 15 mL of water, instead of 10. -One medication was flushed with 20 mLs of water. *Stated the water order was just an estimate and she will give approximately the amount of water that was ordered. <p>Consultant pharmacist P was not available in person or by phone during the survey for interview.</p> <p>5. Interview on 1/5/22 at 3:21 p.m. with Administrator A, Regional Nurse Consultant C, and Interim DON B revealed they:</p>	F 755	<p>biweekly for 1 months and monthly for 4 months to ensure that all stock medications are ordered in a timely manner and available for use. DON/designee will audit 5 random residents a week for 1 month, 5 random residents bi-weekly for 1 month, monthly for 4 months. DON/designee will randomly audit 1 nurse a week for 1 month, biweekly for 1 month, and monthly for 4 months to ensure water flush is measured and administered appropriately as indicated in F684.</p> <p>Results of audits will be discussed by the DON/designee at the monthly QAPI meeting with the IDT and medical director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.</p>	

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F 755	<p>Continued From page 13</p> <p>*Agreed they had instances of running out of medications.</p> <p>*Stated nurses are supposed to inform the supply coordinator when supply is getting low, and that is not always being done.</p> <p>*Use a pharmacy service and they had not always received medications when they had ordered them.</p> <p>*Stated there is sometimes a lack of communication in ordering of medications.</p> <p>*Stated water given during medication administration via PEG tube is to be given as it has been ordered.</p> <p>*Agreed nurses should not sign off inaccurate counts of morphine, and counts should be accurate.</p> <p>6. Review of the provider's November 2017 Medication administration policy revealed:</p> <p>*The director of nursing and consultant pharmacy were to establish a system of records, receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determination that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>*A physical inventory of controlled medications, would be conducted by two licensed clinicians</p> <p>**Any discrepancy in a controlled substance medication count is reported to the director of nursing immediately (the pharmacy must be notified immediately of any e-kit discrepancy). The DON investigates the discrepancy and researches all the records related to medication administration. Medication reconciliation is made from the last known date and time of reconciliation. (e.g. [for example] during the last shift count, receipt of a full medication container, etc.) A thorough search in all drug storage areas,</p>	F 755		

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F 755	Continued From page 14 the resident's room and other locations where medications have been used/placed during the medication administration are made to located any missing container or medication supply." **After a thorough investigation has been completed and the supply cannot be found, a supply must be obtained for the resident." **Document the loss and the investigation process. Notify the prescriber and family if doses have been missed." Review of the provider's January 2021 Gastric Tube Feeding policy revealed: **Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record."	F 755			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880	Directed Plan of Correction Avantara Armour F880 Corrective Action: N. For the identification of lack of: Appropriate wearing of personal protective equipment (PPE). *Appropriate procedural technique during delivery of personal cares. Appropriate hand hygiene and glove use by dietary during meal	1/29/22	

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F 880	Continued From page 15 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880	Service for ready to eat foods and beverages. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Dietary aide D, E; CNAs L, H, J; and all facility staff who provide or are responsible for the above cares will be educated/re-educated on 1/28/22 by Administrator/designee. Identification of Others: 2. ALL residents and staff have the potential to be affected if lack of: appropriate wearing of PPE. appropriate procedural technique during delivery of personal cares. appropriate hand hygiene and glove use by dietary during meal service for ready-to-eat foods and beverages. olicy education/re-education about roles and responsibilities for the above identified assigned area and services tasks will be provided by 1/28/22 by Administrator/desianee.		

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F 880	Continued From page 16 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Staff were wearing surgical masks over their nose and mouths while in direct contact with residents for two of two dietary aides (D and E) and one of two observed certified nursing assistants (CNAs) (L). *Two of two CNAs (H and J) had maintained proper infection control practices while performing cares for one of one resident (10). *Dietary staff (E) handled residents' ready-to-eat foods and beverages with proper infection control practices for one of two observed meal services. Findings include: 1. Observation on 1/4/22 at 7:55 a.m. of the facility's main dining room revealed: *Two dietary aides (D and E) were sitting at a table with other residents who were eating their breakfasts. *Dietary aide D had her mask underneath her nose and mouth, and was about two feet away	F 880	System Changes: 3. Root cause analysis conducted answered the 5 Whys: South Dakota Quality Improvement Organization (QIN) call along with Administrator and Interim DON on 1/17/22 at 1pm discussed infection control practices and felt that the director of nursing resigning and Interim DON B coming to assist facility without having a proper introduction to the ongoings of the facility led to the laps of PPE audits, discussed auditing practices to use and the importance of ensuring audits occur no matter who is in clinical management of the facility. QIN has set audit goals and deadlines that will be submitted to her weekly on 2/1, 2/8, 2/15, 2/22, 3/1, and 3/8 there will be another call to discuss progress, needs to revise, etc. Administrator, Interim DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated	

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F 880	<p>Continued From page 17 from an unidentified resident.</p> <p>*Dietary aide E had her mask underneath her nose, and was sitting in between two residents.</p> <p>2. Observation and interview on 1/4/22 at 8:50 a.m. with dietary aide E working near an unidentified resident with her mask below her nose revealed:</p> <p>*She had started working at the facility again on 1/3/22.</p> <p>*Had worked there for a month and a half prior to November 2021.</p> <p>*Denied receiving any infection control training before starting on 1/3/22.</p> <p>*Had been aware of the purpose for wearing masks and eye shields.</p> <p>3. Observation on 1/4/22 at 10:57 a.m. of CNA L wearing her mask below her nose.</p> <p>4. Observation on 1/4/22 at 11:40 a.m. of personal cares with resident 10 performed by CNA L and CNA J revealed:</p> <p>*They were changing his incontinent brief.</p> <p>*CNA L pushed soiled brief and clean brief under resident 10's back.</p> <p>*With the same soiled gloves, she:</p> <ul style="list-style-type: none"> -Rolled resident over to his other side. *CNA J removed dirty brief and pulled clean brief through. *His perineal area was very red and inflamed. *With the same soiled gloves, CNA J: -Situating clean brief on the resident. -Grabbed cream out of his dresser drawer -Applied cream to his bottom. -Fastened the clean brief. -Put cream back in the dresser drawer. -Placed soiled brief in a garbage bag sitting on resident's bed. 	F 880	<p>competency and documentation. Administrator and Interim DON contacted the South Dakota QIN on 1/23/22 at 4:30pm via email to set up an additional call to discuss the DPOC. Via email QIN advised that since we just had our monthly call that she would review POC and if changes needed to be made to audits she would update and send. On 1/26/22 via email QIN responded with some audit suggestions and advised that she did not feel an additional call would be needed at this time. QIN is available by phone or email if we should have questions or need assistance. They will also provide feedback regarding the audits submitted as they see necessary. Monitoring: Administrator, Interim DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment.</p>	

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F 880	<p>Continued From page 18</p> <p>-Removed her gloves and put on a clean pair. *CNA L straightened resident's gown. *CNA L removed her gloves and washed her hands. *CNA J removed her gloves and placed them in the garbage sack. *Had not performed hand hygiene after removing gloves or exiting the room.</p> <p>Interview on 1/4/22 at 11:57 a.m. with CNA J reviewing steps used with brief changing revealed: *She had not performed hand hygiene after removing her gloves or when she exited the room.</p> <p>Interview on 1/4/22 at 12:03 p.m. with CNA L regarding cares with resident 10 revealed: *She agreed that she had not changed her gloves when moving from dirty areas to clean areas.</p> <p>5. Observation on 1/4/22 during the noon meal from 11:57 a.m. through 12:25 p.m. of dietary aide E revealed: *After putting on a pair of gloves wore them throughout the time. -She filled and served multiple residents beverages holding the rim of the glass or cup with her gloved fingertips. -She served plates of food and desserts. -She reached in and out of the refrigerator and cupboard. -She touched the shoulder of another co-worker with her gloved hand. -In between serving, she rested her gloved hands on the counter.</p> <p>Interview on 1/5/22 at 3:21 p.m. with Administrator A, Interim Director of Nursing B and</p>	F 880	<p>*Staff compliance in the above identified area. Úny other areas identified through the Root Cause AnalysisÚfter 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.</p>	

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F 880	<p>Continued From page 19</p> <p>Regional Nursing Consultant C regarding infection control practices observed revealed they agreed:</p> <p>*Dietary aides D, E, and CNA L should wear face mask properly when providing care or near residents.</p> <p>*During resident care glove changes and hand hygiene were missed.</p> <p>*Dietary aide E had not practiced appropriate infection control techniques during the observed meal service.</p> <p>*The counter top in the kitchen contained areas that were not cleanable.</p> <p>*Those individuals who were not practicing appropriate infection control techniques required re-education.</p> <p>6. Review of the provider's October 2019 Hand Hygiene policy revealed:</p> <p>**All personnel shall be trained and regularly educated on the importance of hand hygiene in preventing the transmission of healthcare-associated infections (HAIs)."</p> <p>**All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."</p> <p>**Employees must wash their hands for at least twenty (20) seconds using an antimicrobial or non-antimicrobial soap and water under the following conditions:"</p> <p>-"a. b. When hands are visibly soiled. "</p> <p>-"b. c. Before and after eating or handling food."</p> <p>**In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all of the following situations:"</p> <p>-"a. Before and after direct contact with residents"</p>	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER AVANTARA ARMOUR			STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK ARMOUR, SD 57313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 20 -"b. When entering and leaving a Resident care area/room" -"c. Before donning and after removing gloves;" -"d. Before performing any non-surgical invasive procedures;" -"e. Before preparing or handling medications;" -"f. Before handling clean or soiled dressings, gauze pads, etc.;" -"g. Before moving from a contaminated body site to a clean body site during resident care; -"h. After contact with a resident's intact skin; -"i. After handling used dressings, contaminated equipment, etc;" -"j. After contact with objects (e.g. [for example] medical equipment) in the immediate vicinity of the resident; and" -"k. After contact with body fluids, mucous membranes and non-intact skin or dressing, provided hands are not visibly soiled."	F 880			

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E 000	Initial Comments Surveyor: 42477 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/4/22 through 1/5/22. Avantara Armour was found in compliance.	E 000		

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

Kassie Doty

TITLE
LNHA

(X6) DATE
02/02/22

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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NAME OF PROVIDER OR SUPPLIER AVANTARA ARMOUR			STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK ARMOUR, SD 57313	
(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 Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/4/22. Avantara Armour 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 K353, K712 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or excuted in compliance with state and federal laws. This plan of correction constitutes with Federal Medicare and Medicaid requirements.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	1. Unable to rectify at the time of the survey. Inspection occurred 1/6/2022. Provider unable to inspect quarterly during 2021 due to Covid-19. 2. All residents could be affected by this deficient practice. 3. Administrator or designee will ensure quarterly inspections are completed timely. 4. Administrator or designee will audit the quarterly fire sprinkler inspection schedule at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director.	01/29/2022

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

Kassie Doty

TITLE

LNHA

(X6) DATE

01/27/2022

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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K 353	Continued From page 1 by: Surveyor: 40506 Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in March or September 2021). Findings include: 1. Record review on 1/4/22 at 2:00 p.m. revealed the required quarterly flow tests had not been performed in the past year. Flow tests in the past twelve months had been performed on 12/29/20, 6/5/21 and 11/10/21. A quarterly flow test had not been performed in March or September 2021. Interview with regional maintenance manager at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712	1. Unable to rectify at the time of the survey. IDT team educated on fire and smoke safety procedure on 01/26/22. 2. All residents could be affected by this deficient practice. 3. Administrator or designee will audit TELS fire drill schedule. 4. Audits of fire drill attendance records and documentation within TELS. Audits will be completed by Administrator or designee biweekly for three consecutive months, then monthly for three months. The Administrator or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.	01/27/2022

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K 712	Continued From page 2 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review, observation, and interview, the provider failed to: *Maintain documentation of fire drills for June, July, August, September, October, November and December 2021. *Ensure staff were familiar with fire drill procedures (Rescure, Alarm, Contain, Extinguish or Evacuate acronym for training). Findings include: 1. Record review on 1/4/22 at 2:45 p.m. revealed the facility had three shifts. During the first three months of 2021 drills were conducted during all three shifts each month. Beginning the second quarter, drills were performed once each month. Documentation of fire drills for the remainder of calendar year 2021 was missing. Interview with the regional maintenance manager revealed that he remembered training the new maintenance manager and performing a drill in October, 2021, however documentation was not found. 2. During the exit interview on 1/4/22 at 4:10 p.m. the acting administrator commented that she believed it had been quite some time since a drill had been conducted, but she did not recall dates. The deficiency had the potential to affect 100% of the building occupants.	K 712		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918	1. Unable to rectify at the time of the survey. Administrator educated on 01/06/22 on weekly and monthly generator run regulations. 2.All residents could be affected by this deficient practice.	01/27/2022

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K 918	<p>Continued From page 3</p> <p>Maintenance and Testing</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 40506</p> <p>Based on record review and interview, the provider failed to perform generator maintenance as required (weekly observations and monthly</p>	K 918	<p>3. Administrator or designee will audit TELS generator maintenance schedule.</p> <p>4. Audits of generator maintenance logs within TELS will be completed by Administrator or designee biweekly for three consecutive months, then monthly for three months. The Administrator or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.</p>		

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K 918	<p>Continued From page 4</p> <p>load runs) for the Cummins 175 diesel generator for 2021. Findings include:</p> <p>1. Record review on 1/4/22 at 3:15 p.m. revealed documentation of weekly and monthly generator runs were consistent from January 2021 through September 8, 2021. The logs for weekly and monthly were different only in that the monthly tests were noted as being under load. No percentage of load was calculated.</p> <p>Interview with the regional maintenance manager at the time of the record review confirmed that finding. He commented that he had provided a new worksheet to the new maintenance man who started in October, and showed him how to calculate load percentage. However, no documentation of generator testing or performance of generator was found. However, a 4-hour load bank test was performed 1-13-21.</p> <p>Failure to perform generator maintenance and testing has the potential to affect all persons in the facility.</p>	K 918		

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER AVANTARA ARMOUR	STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/4/22 through 1/5/22. Avantara Armour was found not in compliance with the following requirement: S121.</p>	S 000	<p>DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or excuted in compliance with state and federal laws. This plan of correction constitutes with Federal Medicare and Medicaid requirements.</p>	
S 121	<p>44:73:02:01 Sanitation</p> <p>The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain a sanitary working surface in the kitchen (ductwork grease filters) and failed to maintain ceiling tiles. Findings include:</p> <p>1. Observation on 1/4/22 at 10:40 a.m. revealed the four stainless steel grease filters situated above the cooking range in the exhaust ductwork had a large amount of lint and grease buildup on them. Interview with the dietary manager revealed the hood and ductwork were on a scheduled monthly cleanup schedule that she believed was contracted. Further interview with the regional maintenance manager on 1/4/22 at 3 p.m. clarified that the filters were to be cleaned by the</p>	S 121	<p>1. Unable to rectify at the time of the survey. Exhaust ductwork cleaned on 01/7/22 and is now on monthly cleaning schedule. Ceiling tiles have been ordered. 2. All residents could be affected by this deficient practice. 3. Administrator or designee will inspect ductwork and cleaning schedule in kitchen area. Install new ceiling tile and inspecting all ceiling tiles within the facility. 4. Administrator or designee will audit cleaning schedule and inspect duct work monthly for three months and quarterly for for 6 months. Ceiling tiles will be audited for compliance monthly for 6 months and quarterly for 6 months. Administrator will review results at Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director.</p>	01/29/2022

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

Kassie Doty

STATE FORM

TITLE

LNHA

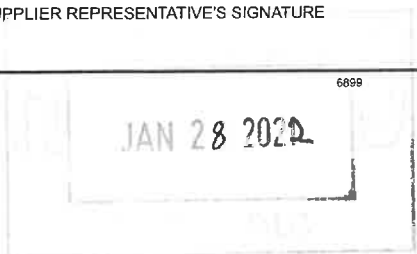
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01/27/2022

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If continuation sheet 1 of 2



South Dakota Department of Health

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S 121	<p>Continued From page 1</p> <p>maintenance staff.</p> <p>2. Observation 1/4/22 throughout the day revealed stained ceiling tiles throughout the facility. Some had been painted, but none were replaced. One in the employee break area toilet room had fallen and not been replaced. Porous ceiling tiles become stained because they have been wet. While wetted they were a growth media for molds and fungi that would have negative affects for the immune compromised until the tiles were removed.</p> <p>Interview with the acting administrator, the regional nurse, and the regional maintenance manager at 4:15 p.m. on 1/4/22 confirmed those conditions. They stated stated scheduled cleaning of the filters would be accomplished. Roof replacement is on the long term plan, but is a capital item to be scheduled.</p>	S 121		