STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/4/24 through 11/7/24. Avantara Saint Cloud was found not in compliance with the following requirements: F550, F583, F584, F684, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/4/24 through 11/7/24. Areas surveyed included the physical environment, infection control, quality of care, quality of treatment, and resident abuse. Avantara Saint Cloud was found not in compliance with the following requirement: F880.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	1. Resident 31 had immediate nail care performed by ADON C upon discovery during survey on 11/6/24. Resident 8 has had all socks removed that had a name of other residents. 2. All residents are at risk. A full house audit of all residents' fingernails and toenails will be completed to ensure appropriate nail care has been provided. A full house audit of all resident clothing will be completed to ensure appropriate resident name is located on the clothing item. These audits will be completed no later than December 22, 2024.	12/22/24

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

Ashley Altena

TITLE Administrator

(X6) DATE 12/02/24

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and South Dakota (SD) State Long-Term Care Ombudsman Program handbook review, the provider failed to ensure: *One of one sampled resident (31) had received diabetic fingernail care to maintain a dignified appearance. *One of one sampled resident (8) was dressed in a dignified manner. Findings include: 1. Observation and interview on 11/5/24 at 9:26 a.m. with resident 31 while she rested in her bed revealed: *She was chewing and sucking on her left index and middle finger and stated she was "hungry."	F 550	(Continued from page 1) 3. Director of Nursing (DON) or designee will educate all nursing staff on the Bathing policy to ensure appropriate nailcare is completed during bathing. This task has been added to Point Click Care (POC) for certified nursing assistants (CNA) to document completion. In addition, an order has been initiated on the Treatment Administration Record (TAR) for completion of nail care by licensed nurse for all diabetic residents. In addition, the DON and/or designee will educate all staff on Resident Rights/Right to Dignity. All donated items for residents have been properly labeled with the new resident's identifying information. Administrator, DON, or designee will educate all nursing and laundry staff on the process that been created for handling donated items and being properly re-labeled. Education will occur no later than December 22, 2024. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. DON or designee will audit 5 residents to ensure nailcare has been completed and documented appropriately by CNA or nurse if the resident is diabetic, as well as audit to ensure resident is wearing appropriately labeled clothing. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 550	Continued From page 2 *Inspection of both hands revealed she had long, uneven, fingernails that extended approximately one-fourth of an inch beyond her finger pads. -There was a dark brown build-up of an unknown substance caked under each fingernail that extended outwards from the edge of each finger pad to the middle of each fingernail. *An odor of feces was detected at her bedside. Observation and interview on 11/6/24 at 9:40 a.m. with the assistant director of nursing (ADON) C and contracted hospice registered nurse (RN) L during resident 31's wound care to her right lateral foot revealed: *ADON C stated she was the provider's wound care nurse. *Hospice RN L stated the resident received a bed bath once weekly from the hospice aides. *Resident 31 was lying in her bed and was sucking on her left index finger during her wound care treatment. *ADON C stated: -Every resident was expected to be provided nail care on their bath days. -Resident 31 was provided fingernail care following every meal, or at a minimum of once daily as the resident "liked to dig [in her feces]." -Since resident 31 was a diabetic, the resident's charge nurse was expected to provide her fingernail care. A podiatrist provided her with toenail care. *Both ADON C and hospice RN L confirmed resident 31's fingernails were long and caked with a brown substance. Review of resident 31's electronic medical record (EMR) revealed: *She had been on hospice care since April of 2024 for end-of-life care related to multiple	F 550		

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F 550	Continued From page 3 co-morbidities that included: advanced dementia with agitation, late-onset Alzheimer's disease, congestive heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, cerebrovascular disease, and type 2 diabetes mellitus with peripheral angiopathy with gangrene. *She had a Brief Interview for Mental Status (BIMS) assessment score of four, which indicated she had severe cognitive impairment. *She was dependent on staff for all her hygiene needs including bathing, personal hygiene, and incontinence care. *A nurse provided a daily dressing treatment to her right foot and completed with weekly assessments of her skin. *Review of her physician's orders, treatment orders, nursing documentation, and CNA care task documentation had not indicated when and by whom nail care was to have been completed. On 11/6/24 at 1:37 p.m., a request was made to the provider for a nail care policy and documentation of resident 31's completed fingernail care. Interview on 11/6/24 at 3:20 p.m. with the director of nursing (DON) B regarding resident 31's fingernail observations and nail care revealed: *She stated the nail care policy was included in the bathing policy. *She stated they had no documentation of when her diabetic nail care was completed, but it was her expectation the bathing policy would have been followed by staff, which indicated nail care would be performed with each bath. -Diabetic nail care was expected to be performed by the nurses and all the nurses were expected to know this was to occur on the resident's bath	F 550		

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F 550	Continued From page 4 days. *She confirmed the performance and documentation of diabetic nail care needed to be improved. Review of the provider's August 2023 bathing policy revealed: *"Fingernails and toenails should be inspected on bathing days and nails should be trimmed and filed as necessary. CNAs (certified nurse aides) will not perform nail care on residents with diabetes." *The policy had not addressed who was expected to provide and document diabetic nail care. 2. Observation on 11/5/24 at 9:45 a.m. of resident 8 in her room revealed she: *Was laying on her side asleep in bed. -Wore socks labeled with her roommate's name on them. Observation on 11/6/24 at 9:30 a.m. of resident 8 in her room revealed she: *Was seated in her wheelchair watching television. -Wore socks labeled with an unknown resident's name on them. Review of resident 8's 8/27/24 Minimum Data Set assessment revealed: *Her cognition was severely impaired. -She rarely made her own decisions. Interview on 11/6/24 at 10:00 a.m. with certified nurse aide K regarding resident 8 revealed: *Staff had chosen the clothes she wore each day. *The resident had her own socks. -The socks that were put on her that morning	F 550		

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F 550	Continued From page 5 were donated. Review of the August 2019 SD State Long-Term Care Ombudsman Program handbook revealed: *Dignity and Quality of Life: -All residents were entitled to reasonable quality of life including: "2. To be treated with consideration, respect, and dignity. Recognition of your, and every resident's, individuality."	F 550		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583	1. New window coverings that provide privacy for the resident(s) were ordered immediately upon discovery. The invoice was finalized, and window coverings were set for production on 11/15/24. No immediate action could be taken for the unlocked medication cart and computer screen remaining open to display the Electronic Medical Record (EMR). 2. All residents with that style of window coverings noted are at risk. All residents are at risk due to an unlocked medication cart and/or an unsecured EMR computer screen. A full house audit will be completed of all resident rooms to ensure the style of window covering allows for resident privacy. 3. DON and/or designee will provide education to all nurses and medication aides on the Medication Administration General Guidelines policy to ensure medication cart is locked when not attended and that resident's health information remains private by ensuring the Medication Administration Record (MAR) is closed or covered when not in direct use.	12/22/24

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F 583	Continued From page 6 provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, South Dakota (SD) State Long-Term Care Ombudsman Program handbook review, and policy review, the provider failed to ensure: *Window coverings in 12 of 14 resident rooms (301, 302, 303, 304, 305, 306, 307, 309, 311, 312, 314, and 316) located in the 300 Hall had protected those residents' right to privacy. *Window coverings in 5 of 9 resident rooms (105, 107, 111, 113, and 115) located in the 100 hall had protected those residents' right to privacy. *One of 14 residents' (2) electronic medical records (EMR) were secured and not accessible to other residents, staff, or the public. *One of two medication carts were locked and medications were not accessible to other residents, staff, and the public by one of one registered nurse (RN) J in the Main dining room during the noon medication pass. Findings include: 1. Observation on 11/4/24 at 7:15 p.m. on the sidewalk leading to the main entrance of the facility revealed: *Resident rooms on the north side of the 300 hallway ran parallel to that sidewalk. -The windows in those rooms faced the visitor's parking lot. *The inside of those rooms were visible despite the window shades in those rooms having been	F 583	(Continued from page 6) RN J will be included in this education. DON or designee will educate all staff on the Resident Dignity & Privacy policy to ensure resident's dignity and privacy is maintained by having appropriate window coverings that do not allow visibility in resident rooms from the outside. Education will occur no later than December 22, 2024. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. DON and/or designee will audit nurses and/or medication aides, to include RN J, during five medication pass occurrences to ensure medication carts are locked while unattended and the MAR on computers are closed when unattended to maintain the privacy of residents. Administrator and/or designee will conduct auditing and monitoring of five resident rooms and window coverings to ensure privacy is maintained. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 583	Continued From page 7 pulled down. *Resident rooms on the south side of the 300 hallway had the same type of window shade coverings. -Those windows faced an employee parking lot. Observation on 11/5/24 at 7:30 a.m. on the same sidewalk referred to above revealed the insides of the residents' rooms on the north side of the 300 hallway were not visible through the pulled down window shades during daylight hours. Observation and interview on 11/5/24 at 4:50 p.m. with administrator A on the sidewalk above revealed: *The insides of the resident rooms on the north side of the 300 hall were visible despite the window shades having been pulled down. *Administrator A had not known the pulled window shades failed to protect the privacy of the residents who occupied those rooms. Review of the August 2019 SD State Long-Term Care Ombudsman Program revealed: *Privacy and Confidentiality -"You have the right to privacy and confidentiality regarding personal, financial, and medical affairs." 2. Observation on 11/5/24 at 8:30 a.m. of the 100 hallway resident rooms revealed: *Five of the nine rooms (105, 107, 111, 113, and 115) that faced the north-sided public sidewalk and parking lot contained the same type of shade observed above in the 300 hallway that allowed unobstructed night-time viewing of the resident's rooms when pulled down. -Those shades provided resident with privacy	F 583		

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F 583	Continued From page 8 during the daylight hours only. -Those rooms did not contained any other type of window covering to ensure resident privacy at night. 3. Observation and interview on 11/6/24 at 11:20 a.m. with RN J the main dining room during a medication pass revealed: *She had been preparing medications for the residents' who were seated in the main dining room. *She prepared resident 2's medications, placed the medications in a medication cup, and verified the medications were correct as indicated in the resident's medication administration record (MAR). *She returned resident 2's medication card in the medication cart. *She picked up the medication cup with the resident's medications and walked over to the resident. -She left the medication cart unlocked and the computer screen open that displayed resident 2's EMR information. -Multiple staff members walked by the unlocked cart to wash their hands at the sink. -Her back was turned away from the medication cart while she assisted the resident with her medications. *RN J agreed the screen should not have been left open and should have been shut. *RN J agreed the medication cart should have been locked when she walked away from the medication cart. Interview on 10/6/24 at 2:52 p.m. with director of nursing (DON) B regarding the above observation revealed:	F 583		

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F 583	Continued From page 9	F 583		

*She expected the staff to minimize or lock the computer screen and to make sure the medication cart was locked, and the keys were always with them.

Review of provider's September 2019 Resident Dignity & Privacy policy revealed:
*"Policy."
-"It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy."
-"18. Protected Health Information should not be in viewing area of public. This includes computer screens, resident room listing, report forms, etc."

Review of provider's September 2018 Medication Administration General Guidelines policy revealed:
*"Policy"
-"Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication."
-"Procedures"
--"Medication Administration"
--"17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse."
--"18. Resident's health information needs to remain private. The pages of the MAR [Medication Administration Record] notebook containing resident health information must remain closed or covered when not in direct use."

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F 584 F 584 SS=E	Continued From page 10 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584 F 584	1. A corrective plan has been put into place for rooms #301, 309, 311, 312, 314, 316, 202, 204, 206, 207, 209, 103, 104, 108, 110, 115, and 117. The above rooms with areas of exposed sheetrock, missing paint, and gauges in the walls are being repaired. The recliner in room 303 was discarded as it was no longer a cleanable surface and unable to be repaired. The stain of a black substance in room 304 was cleaned upon discovery on 11/5/24. The black marker outline in room 312 was unable to be removed and was painted over. The privacy curtain in room 207 was removed and replaced with a clean privacy curtain. The electrical outlet cover in room 115 was replaced on 11/6/24. 2. All residents and resident rooms are at risk. A full house audit of all resident rooms was completed to ensure a home like environment is maintained for each room. 3. Facility leadership ensured all staff have proper access to the Technology for Enhanced Living Solutions (TELS) system to report maintenance needs in a timely manner. A system for touch up painting and repairs has been implemented. Areas of concerns noted by staff members will be reported to the maintenance director as needed and monthly audits and facility walk-throughs of the resident rooms will occur with touch up painting and repairs completed at that time. Non-slip pads have been ordered to be placed under the recliners to help reduce the frequency of the recliners scratching against the wall. Administrator and DON will complete education with all staff on the proper usage of the TELS system.	12/22/24

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F 584	Continued From page 11 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 policy review, the provider failed to maintain a clean and homelike environment for: *8 of 14 resident rooms (301, 303, 304, 309, 311, 312, 314, and 316) on the 300 hallway. *5 of 22 resident rooms (202, 204, 206, 207 and 209) on the 200 hallway. *6 of 23 resident rooms (103, 104, 108, 110, 115, and 117) on the 100 hallway. Findings include: 1. Random observations on 11/5/24 between 9:30 a.m. and 3:35 p.m. inside the rooms on the 300 hallway revealed: *Room 301 had areas of exposed sheetrock near the foot and head of the bed, and behind the headboard of that bed which was positioned along the wall beneath the window. -There was an area of exposed sheetrock near the head of another bed that was positioned along the wall near the doorway of that room. *In room 303, the recliner's headrest was worn and no longer a cleanable surface. *Room 304: There was an area approximately 12 inches by 12 inches on the wall beneath the window near the foot of the bed that appeared to have been a spill of a black substance that had run down that wall. *Room 309 had an area of the baseboard molding along the wall between the bathroom door and the south wall that was missing. The exterior doorframe of the bathroom had multiple areas where the paint was missing.	F 584	(Continued from page 11) Administrator and DON will complete education with the housekeeping and nursing staff on the Homelike Environment policy. Education will occur no later than December 22, 2024. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. Administrator, Maintenance Director, and/or designee will conduct auditing and monitoring of five resident rooms to ensure a homelike environment is maintained. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator, Maintenance Director, or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 584	Continued From page 12 *Room 311 had areas of exposed sheetrock near the foot and head of the bed that was positioned on the wall beneath the window. -There was an area of exposed sheetrock behind the headboard of another bed that was positioned along the wall opposite of the window. A crack extended from the top to the bottom of that wall. *Room 312 had an approximately six inches long by three inches wide oval-shaped outline that appeared to have been made by a black marker on the wall beneath the window. *Room 314 had areas of exposed sheetrock on the walls near the heads of both beds. -There were multiple scratch-like gouges exposing the sheetrock on the wall behind the recliner. *Room 316 had areas of exposed sheetrock on the wall by the window near the head and foot of the bed. -There were areas of exposed sheetrock at the head and midsection of the bed positioned on the wall opposite of the window. 2. Random observations on 11/5/24 between 9:00 a.m. and 5:45 p.m. of the inside of the rooms in the 200 hallway revealed: *Room 202: Had areas of missing paint on the wall behind the headrest of the recliner. -There were multiple scratch-like gouges from the bottom of the floor to 12 inches up fron the entrance and the bathroom doorframes. *Room 204: There were multiple scratch-like gouges from the bottom of the floor to 12 inches up of the entrance and bathroom doorframes. -There was missing portion of the door panel on the front portion of the entrance door. *Room 206: Had an area of exposed sheetrock positioned along the wall next to the sink, and two	F 584		

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dime-size holes inside the exposed sheetrock.
*Room 209: Had multiple scratch-like gouges from the bottom of the floor to 12 inches up from the bathroom doorframe.
-There was an approximate ten-inch long by ten-inch wide white square-shape patch on the wall next to the toilet.

3. Observation on 11/4/24 at 3:05 p.m. in room 207 revealed:
*Gouges and areas where paint was scraped off both sides of the doorframe entering the resident's room.
*Multiple areas of missing paint and exposed sheetrock on the wall that extended the length of the resident's bed.
*Gouges and areas where paint was scraped off both sides of the bathroom doorframe.
*A large area of paint was scraped off the wall opposite the sink in the bathroom.
*A privacy curtain in the room was visibly soiled and had an area with an unknown brown substance on it.

4. Random observations on 11/4/24 from 1:45 p.m. through 4:55 p.m. of the resident rooms located in the 100-hallway revealed:
*Room 103: Had several areas of missing paint and exposed sheetrock that included a wall above the left side of the mattress that covered a two-foot long by one-foot-wide area, and a wall near the right side of the bed's headboard that measured approximately six inches long by three inches wide.
-In the opposite corner of the room, there were scattered areas of missing paint and exposed

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F 584	Continued From page 14 sheetrock located on the wall next to each side of a recliner chair. *Room 104: Had two linear sections of missing paint and exposed sheetrock located above the bed mattress and at the foot of the bed. *Room 108: Had several areas of missing paint and exposed sheetrock located along the wall under the window right above the resident's mattress, and a visible linear crack of peeling paint located at the resident's head of the bed where the room's outside wall and inside wall joined. It extended nearly the entire height of the room. *Room 110: Had scattered areas of missing paint and exposed sheetrock throughout the room including on a wall next to a dresser holding a television, and along the doorway entrance into the bathroom. *Room 115: Had multiple areas of missing paint and exposed sheetrock throughout the room along three of the four walls. -There was an electrical outlet cover that was broken with half of the cover missing and the interior of the outlet exposed. It was located slightly above the resident's mattress. -There were two-dime sized holes in the wall by the sink and missing paint on the doorway leading into the bathroom. *Room 117: Had several areas of missing paint and exposed sheetrock located along the wall under the outside window. Observation and interview on 11/6/24 at 1:38 p.m. with interim maintenance supervisor H during a walking tour of several of the above-mentioned rooms revealed: *He stated the prior maintenance supervisor had resigned approximately one-and-a-half weeks ago.	F 584		

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F 584	Continued From page 15 *He worked full-time at a sister facility and had planned on coming to this facility two to three times a week. -He stated there was a maintenance supervisor from another sister facility who could "fill in" as needed. *They were able to receive the provider's maintenance repair requests through an electronic communication system called TELS (technology for enhanced living solutions). *He stated: -The maintenance department was responsible for overseeing the housekeeping department along with a "head" housekeeper. -He depended on staff and housekeeping supervisor G to submit reports of any building maintenance issues into TELS. -He was aware of some spackling and painting of resident rooms had occurred because he had to educate the prior maintenance supervisor on how to spackle drywall. -He knew there had been contract painters brought in during the last year to repair, paint, and remodel resident rooms. -He thought there were not many rooms remaining that needed to be completely painted. -"...of course there is always a need for [paint] touch-ups, door jams, and those type circumstances." *He was not aware of any rooms that needed immediate repair or touch-up painting. *Following a walk-through and random inspection of several of the above-mentioned rooms, he stated he had not been aware there were multiple rooms that needed paint touch-ups and confirmed the rooms appearances were not "homelike." -He had not been aware of the broken outlet cover in room 115.	F 584		

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F 584	Continued From page 16 *He stated his expectation as a maintenance supervisor, would be to perform a monthly walk-through inspection of resident rooms for needed paint touch-ups and repairs. He was not aware when that had last occurred in this facility. *He stated painting and repairs were difficult to complete because a resident's room had to be empty to repair or paint the room. Interview on 11/06/24 at 4:00 p.m. with administrator A regarding multiple rooms with missing paint, exposed sheetrock, and maintenance repair needs revealed: *It was her expectation for the staff to fill out a TELS maintenance request on any urgent repair needs. -She stated everyone had access to the electronic TELS system. *She had contracted painters and sheetrock repair men working on repairing each room that was identified through an audit as needing paint and repairs. -The contractors had been repairing and painting one room at a time on the weekends when they were available. -She confirmed that according to their 2022 South Dakota Department of Health survey and plan of correction for a homelike environment, there had been a designated empty room to move a resident into while the resident's room was being painted and repaired. However, they had an emergency resident admission in October and were "room blocked (no empty room)" from continuing with the scheduled painting and repairs. Review of the 2024 contracted drywall and paint invoices revealed seven visits in 2024 (3/20, 5/1, 6/3, 6/7, 9/18, 9/21, and 10/5/2024) had occurred.	F 584		

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F 584	Continued From page 17 Resident rooms that had been billed as completed were listed as rooms 104, 205, 303, 308, and 314. There were other repairs listed in those invoices that were not related to resident rooms. Further interview on 11/7/24 at 7:43 a.m. with administrator A regarding paint touch-ups and room repairs performed in between complete room painting revealed: *She was actively trying to hire a full-time maintenance person. *They planned on resuming with complete room painting next week, as an empty room had just become available. She stated room painting was a slow process. *Regarding preventative room maintenance she stated: -Touch-up painting had occurred in the past, but they had "backed off as we were looking at permanent fixes." -"I should have given more directive to follow through with completion of touch-ups." *She confirmed paint touch-ups should have occurred in between a complete room repainting and agreed the missing paint and exposed drywall had created an uncleanable surface and was not a homelike environment for the residents who resided in those rooms. Interview on 11/7/24 at 8:41 a.m. with housekeeping supervisor G revealed: *He had worked as the housekeeping supervisor for one year. *He agreed numerous rooms had scratched paint and exposed drywall. -He stated he verbally told (name of prior maintenance supervisor) when he received a report of a room in need of repair.	F 584		

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F 584	Continued From page 18 *He stated none of the housekeeping or laundry staff had log-in access to the electronic TELS maintenance system. Review of the provider's October 2019 Homelike Environment policy revealed: *"Policy: Residents are provided with a safe, clean, comfortable homelike environment and encouraged to use their personal belonging to the extent possible." -"2. i. Walls and door scuffs/chips repaired with paint/stain when needed[.]" -"3. The facility will have a mechanism for reporting disrepair to Maintenance personnel and staff will be educated on the process."	F 584		
F 684 SS=D	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, record review, and job description review, the provider failed to ensure physician's orders were followed for the use of: *TED Hose (thromboembolic deterrent compression stockings used by non-ambulatory residents) by one of one sampled resident (39). *Redi-Wraps (adjustable compression wrap) by one of one sampled resident (8).	F 684	1. Resident 39 was provided the proper thromboembolic deterrent (TED) Hose stockings on 11/07/2024. Resident 8 Redi-Wraps were returned from laundry on 11/06/2024 and were applied as ordered. A back up pair of Redi-Wraps have been supplied for Resident 8 as well. Resident 65 was ordered personal compression stockings from Hospice Home Health company. The compression stockings arrived on 11/11/24. 2. All residents with physician ordered treatments to apply compression stockings, hose, and wraps are at risk. A full house audit of all residents with a physician order to apply all styles of compression stockings or wraps will be completed to ensure the proper supplies are available for each identified resident. This audit will be completed no later than December 22, 2024.	12/22/24

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F 684	Continued From page 19 *Gradual compression stockings (compression stockings that are tightest around the ankle and gradually loosen up the leg) by one of one sampled resident (65). Findings include: 1. Observation and interview on 11/4/24 at 2:26 p.m. with resident 39 in her room revealed: *She was sitting in her recliner with the leg rests elevated. -On the wall behind her recliner was a sign that read "Ted Hose on in AM and off in PM." *The resident was wearing regular socks on her feet. -She had no TED Hose that fit her and had not worn TED Hose since the summer. Observations on 11/5/24 at 9:11 a.m. and again on 11/6/24 at 9:41 a.m. of resident 39 in her room revealed she was sitting in her recliner with the leg rests elevated wearing regular socks on her feet. Review of resident 39's electronic medical record (EMR) revealed: *Her diagnoses included heart failure. *A 12/23/23 physician's order: "TED hose on in the AM and off in the PM related to LE [lower extremity] edema [fluid retention]." *Her November 2024 Treatment Administration Record (TAR) revealed it was documented from 11/1/24 through 11/5/24 that TED Hose had been put on her feet each of those mornings and removed each evening. 2. Observations on 11/4/24 at 2:54 p.m., 11/5/24 at 9:45 a.m., and again on 11/6/24 at 9:45 a.m. of resident 8 in her room revealed: *She was either lying in her bed or sitting in her	F 684	(Continued from page 19) 3. An adequate supply of items for physician ordered treatments was obtained until the facility shipment arrives. DON and/ or designee will provide education to all nursing department staff and Central Supply staff on the process of ensuring adequate supplies are available for physician ordered treatments and on the process of documenting completion of physician-ordered treatments on the TAR, to include those delegated to a C.N.A. RN J and Central Supply staff F will be included in this education. The DON or designee will provide education to all licensed nurses on the "Following Physician Orders" policy. Education will occur no later than December 22, 2024. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The DON and/or designee will conduct auditing and monitoring of 5 residents for proper completion of physician-ordered treatments, documentation of treatments, and ensuring an adequate supply is kept on hand. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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wheelchair during those times.
*A sign near the head of her bed read "Put on leg wraps in AM and off in PM."
-At the time of each observation above the resident was wearing regular socks on her feet.

Review of resident 8's EMR revealed:
*Her diagnoses included edema.
*A 2/14/24 physician's order: "Redi-Wraps to bilateral LE [lower extremities] and remove per schedule."
*Her November 2024 TAR revealed it was documented from 11/1/24 through 11/5/24 that Redi-Wraps had been put on the resident each of those mornings and removed each evening.

3. Observations on 11/4/24 at 3:07 p.m., 11/5/24 at 9:38 a.m., and again on 11/6/24 at 9:57 a.m. of resident 65 in her room revealed:
*She was sitting in her recliner wearing regular socks on her feet and a pair of Crocs foam sandles.
*A foot cradle [a device attached to the foot of the bed that kept sheets and blankets from touching or rubbing the legs and feet]was at the end of her bed.

Review of resident 65's EMR revealed:
*Her diagnoses included chronic embolism and thrombosis (blood clot formation) of the left femoral vein.
*A 9/13/24 physician's order: "Knee high 20-30 gradual compression stockings. On in am, off at HS [nighttime]. One time a day for left leg edema and remove per schedule."
*A 9/13/24 progress note that indicated the resident's stockings were ordered through a local home health equipment provider.
*Her November 2024 TAR revealed it was

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documented from 11/1/24 through 11/5/24 that her compression stockings had been put on each of those mornings and removed each evening.

Interview on 11/6/24 at 9:50 a.m. with certified nurse aide (CNA) K revealed:
*Resident 39 was waiting for a new pair of TED hose to replace her pair that were ripped.
-Nursing staff were informed the resident had no other TED hose to wear.
-She had been without TED hose for "a few days."
*Resident 8's Redi-Wraps had not returned from the laundry.
-She had only one pair of Wraps.
*Resident 65's compression stockings were too tight and she needed different-sized stockings.
-Her family was expected to provide those.

Interview on 11/6/24 at 2:50 p.m. with registered nurse (RN) J regarding the physician-ordered treatments above for residents 8, 39, and 65 revealed:
*She had documented in residents 8, 39, and 65's TARs the Redi-Wraps, TED hose, and compression stockings had been put on those residents on the morning of 11/6/24.
*CNA staff had dressed residents 8, 39, and 65 that morning.
-That would have included their hose and stockings.
*She had not known resident 8 had no Redi-Wraps, resident 39 had no TED hose, and resident 65 had no compression stockings.
-Resident 8 should have had a back-up pair of wraps to wear and another pair of TED hose should have been obtained from the central supply room for resident 39. Resident 65's hospice nurse should have been contacted about

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F 684	Continued From page 22 providing her compression socks. Observation on 11/6/24 at 4:40 p.m. of the central supply room revealed there were: *Two packages of size large Redi Wraps and two packages of size extra-large Redi-Wraps. *Multiple packages of size small TED hose. Interview on 11/7/24 at 10:15 a.m. with Qualified Activity Director (QAD)/Central Supply staff F revealed: *She had been responsible for maintaining the facility's central supply room since August 2024. *She had known residents were without their physician-ordered compression socks, TED hose, and Redi-Wraps. -Resident 65's compression stockings were ordered through a specialty supply company "a few weeks ago." -In the last week, she had unsuccessfully attempted to order the other supplies from various vendors. *She had notified the facility's corporate office of her difficulty in getting resident supplies. -On 11/6/24 she had talked with administrator A. Administrator A was contacting local sister facilities to determine if they were able to help obtain those needed resident supplies. *QAD/Central Supply staff F did not know how many residents required physician-ordered hose, stockings, and wraps or how many of those items were expected to have been on hand in the event a second pair was needed. Interview on 11/7/24 at 10:45 a.m. with director of nursing B revealed: *Physician-ordered treatments for residents 8, 39, and 65 were not provided. *Nursing staff were expected to not document	F 684		

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F 684	Continued From page 23 completion of physician-ordered treatments delegated to a CNA in a resident's TAR without first visually confirming for themselves the treatment had been completed. *She agreed a process was needed to ensure an adequate number of supplies were kept on hand for residents who required physician-ordered compression stockings, hose, and wraps. Review of the provider's updated 12/1/19 RN Floor Nurse job description revealed "12. Administer or supervise all treatments prescribed by physicians..."	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, job description	F 812	1. Cups found to have build-up that was not easily removed have been discarded. The top surface of the plate warmer has been cleaned. The measuring cup used with the coffee maker has been discarded and replaced. The window ledge and window frame above the coffee maker has been cleaned. The knife holder has been cleaned and a new version for knife storage has been ordered. The cooking utensil storage drawer has been cleaned. The Saf-T-Wrap dispenser and holder has been cleaned. The storage rack under the oven stand has been cleaned and film removed. The fluorescent light plastic covering has been replaced with a new covering. Testing strips for sanitation to water disinfection were replaced with non-expired testing strips. The slats of the air conditioning unit were cleaned. No immediate action could be taken for the improper handling of the insulated covers and transporting of uncovered food.	12/22/24

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F 812	Continued From page 24 review, and policy review, the provider failed to ensure: *The kitchen and dishroom were maintained in a clean and functional manner. *Food items placed on trays and delivered to residents to eat in their rooms (room trays) were kept covered during transport until they were delivered to their rooms. *Insulated dinner plate covers were handled in a sanitary manner. Findings include: 1. Observation and interviews with food service manager (FSM) E, cook N, and dietary aide O on 11/4/24 from 5:00 p.m. through 6:40 p.m. during the initial kitchen tour and the evening meal service revealed: *Plastic drinking cups were being filled for the evening meal by cook N. -Twelve of 20 unfilled cups on one of two trays had white-colored build-up on their bottoms and/or their insides. Scratch-like marks on the insides resembled scrub brush marks. *FSM E stated the cup discoloration was lime build-up and commented to cook P "Are you the only one who knows how to use a brush?" *One side of the dual plate warmer near the serving area held regular plates and the other side held adapted blue plates with raised edges. The side of the warmer that contained the blue plates was not working. -The top surface area of that plate warmer including the areas around the openings where the plates were removed from was littered with food crumbs. -FSM E was aware the warmer was not functioning properly and agreed the top of the unit was unclean. *Near the coffee makers was a four-cup plastic	F 812	(Continued from page 24) 2. All residents could be at risk. A full audit of the kitchen and dish room area will be completed to ensure all areas are maintained in a clean and sanitary manner. 3. Administrator and Culinary Environmental Service (EVS) Consultant provided education to the Food Service Manager and Dietary Department staff on proper cleanliness and sanitary procedures in the kitchen area and handling of dishware and transportation of food. The kitchen area received a thorough cleaning and new daily and weekly cleaning checklists were implemented. Cleaning duties will be monitored by the Food Service Manager or designee. A Directed In-service Training is scheduled to occur prior to December 7, 2024, with the Administrator, Dietary Manager, and Registered Dietician in collaboration with the Medical Director. The Administrator and Culinary EVS Consultant have provided education and training for all dietary staff, to include the Dietary Manager, responsible for the assigned tasks to ensure the kitchen environment and equipment is maintained in a clean and sanitary manner. Section 8 of the Crandall policy and procedure manual, titled "Equipment Operation, Infection Control and Sanitation" was reviewed by the Administrator, Dietary Manager, and Registered Dietician in collaboration with the Medical Director.	

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F 812	Continued From page 25 measuring cup that was stained brown throughout its inside. Cook N stated coffee from the coffee makers was poured into that cup then transferred to carafes for serving. -FSM E said the cup should no longer have been used since it was unable to be thoroughly cleaned. *The window ledge and window frame above the coffee makers was covered with a brown-colored film of unknown origin. *On the cook's prep table was a knife holder attached to the side of that table. The surface of the holder and in and around where the knives were inserted was covered with food crumbs that were not removable when swiped with a finger. -Cooking utensils were stored in a lined drawer attached to the cook's prep table. The liner resembled a plastic net. There were dried food particles in the open areas of the liner. -A Saf-T-Wrap (plastic wrap) dispenser holder was opened and was on top of the cook's prep table. The inside of the opened lid had individual compartments for holding things like packaged alcohol pads and pre-printed food labels. The bottoms of those compartments had a build-up of an unknown substance on them. The area surrounding the opening where the plastic wrap was pulled through to be torn off had an unknown build-up around it. *Beneath the Vulcan oven stand was an open area of racked storage for cookie sheets and baking pans. The surface on both sides of those racks was covered with a film of unknown origin and was unable to be removed when swiped with a finger. *A fluorescent light was on the ceiling between refrigerator units one and two and freezer units one through three. The plastic light covering was cracked and broken.	F 812	(Continued from page 25) 4. Administrator, Dietary Manager and/ or designee will conduct auditing and monitoring to ensure all areas within the kitchen, dish room, and food preparation areas are maintained in a clean and sanitary manner. Audits of five kitchen areas will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Dietary Manager or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 812	Continued From page 26 *The test strips in the dishroom used to measure the concentration of sanitizer to water for disinfection had expired in September 2022 but were still being used. -FSM E was made aware of the expired strips "last week" by a service technician. She had not known the test strip holder was labeled with an expiration date. She had not reached out to a sister facility for unexpired test strips to use while she waited for new strips to arrive. *The individual slats of the air conditioner that was running in the dishroom were covered with a film of gray dust. -The air was blowing over clean dishware and a metal rack that held clean cooking pots, pans, soup bowls, cutting boards. *Dietary aide O was responsible for loading and transporting prepared resident food trays in an insulated cart to three of four dining rooms. -She used her bare hand to hold the inside of the insulated covers until she placed them over the top of the individually prepared resident meal plates instead of using the knob on top of the covers to hold them in a sanitary manner. -FSM E and dietary aide O both agreed not having used the knob to hold the covers increased the risk of cross-contamination of resident food items. *Room trays with covered drinking cups and uncovered dishes of mixed fruit sat on the cook's prep table from 6:15 p.m. through 6:40 p.m. At 6:40 p.m. when the room tray was completely plated and covered with an insulated cover. An unidentified aide then transported that room tray out of the dining room to a resident room with the fruit still uncovered. -FSM E had not noticed the length of time the uncovered fruit sat waiting to be delivered or that the fruit remained uncovered during transport.	F 812		

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F 812	Continued From page 27 Interview on 11/6/24 at 8:45 a.m. with FSM E revealed: *Individual cleaning checklists were developed for the morning and evening cooks, dietary aides, and dishwashers. -The checklists included daily and weekly cleaning assignments that were initialed by the staff person who had completed those tasks. *FSM E was responsible for regularly reviewing the kitchen cleaning tasks checklists for completion of those tasks by her staff. Review of the provider's updated 12/1/19 Director of Dietary Services job description revealed: *Essential Functions: -"2. Operates the dietary department in a safe and sanitary manner by ensuring compliance with federal, State, and local regulations and following established policies and procedures." -"12. Assure that established infection control and prevention practices and standard precautions are maintained at all times." Review of the provider's revised 9/1/18 Accident Prevention In Food Transport policy revealed: "3. Food should remain covered when in transit."	F 812		
F 880 SS=F	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.	F 880	1. Upon discovery, the soiled linen and garbage containers were emptied to allow for proper lid closure. The soiled utility room was thoroughly deep cleaned, and the containers cleaned and sanitized. The wall above the bed in room 108B has been cleaned. The dust in the laundry room has been removed and cleaned. Repairs to the leaking pipe have been scheduled with the contracted plumber.	12/22/24

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F 880	Continued From page 28 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (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	F 880	(Continued from page 28) The handwashing sink in the laundry room has been bleached to remove the orange-colored build-up. The basket of shoes and slippers in the clean laundry room was immediately removed after discovery. Resident 58 had the recliner removed and replaced with a new recliner with a more cleanable surface. 2. All residents and resident areas are at risk. A full house audit will be completed to ensure cleanliness is maintained throughout the facility and all recliner cleanliness is intact. These audits will be completed no later than December 22, 2024. 3. Administrator and Culinary EVS Consultant provided education to the Housekeeping Supervisor G on proper cleanliness procedures for all areas of the facility. All identified areas within the facility (to include resident rooms, soiled utility rooms, and laundry areas) are receiving a thorough cleaning. Updated daily, weekly, and monthly cleaning checklists were implemented. Cleaning duties will be monitored by the Housekeeping Supervisor or designee. A Directed In-service Training is scheduled to occur prior to December 7, 2024 with the Administrator, DON, Housekeeping Supervisor, Culinary EVS Consultant, housekeeping, and laundry staff in collaboration with the Medical Director. The Administrator, DON, and Culinary EVS Consultant have provided education and training for all EVS department staff and nursing department staff for the assigned tasks to ensure the identified areas are maintained in a clean, sanitary, and home like manner.	

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F 880	Continued From page 29 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain the environment and resident use items in a clean and odor-free condition for: *A soiled utility room located directly across from the entrance into the secured unit. *Two of sixteen sampled resident rooms (103 and 108) located in the 100 hallway. *One of one laundry room. *One of one clean utility room located in the secured unit. *A urine-soaked chair from one of one sampled resident's (58) room. Findings include: 1. Observation during the initial tour on 11/4/24 at 12:45 p.m. revealed a strong urine odor upon entrance through the double doors that led into the secured unit of the building where the 100, 200, and 400 hallways were located.	F 880	(Continued from page 29) The "Housekeeping Service Policies and Procedures" manual will be reviewed by the Administrator, Housekeeping Supervisor and Contracted EVS Consultant in collaboration with the Medical Director. All education will be completed no later than December 7, 2024. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. Administrator, Housekeeping Supervisor, and/or designee will conduct auditing and monitoring of five facility areas and recliners to ensure all identified areas are maintained in a clean, sanitary, and home like manner. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Housekeeping Supervisor or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 880	Continued From page 30 Observation on 11/5/24 at 1:48 p.m. and at 1:52 p.m. revealed a strong urine odor was again present upon entrance into the secured unit described above. *A soiled utility room was located directly across the hall from the entrance into the secured unit. -That room had soiled linen and garbage containers in it that were overflowing with soiled clothing, soiled incontinence briefs, and garbage, which caused the container's lids to remain open. -A putrid odor of urine and feces emanated from those containers. -At 1:52 p.m., those items had been removed from the containers and clean liners had been placed in the container however the room continued to emit a strong odor of urine and the floor was sticky. 2. Observation on 11/4/24 at 2:00 p.m. of room 103 revealed the room had a strong odor of urine and the bathroom floor was sticky with an odor of urine. Observation on 11/4/24 at 3:02 p.m. of room 108B revealed visible brown fingerprint smudges along the wall right above the resident's mattress. Interview on 11/7/24 at 8:20 a.m. with housekeeper Q regarding cleaning and mopping of resident rooms revealed: *He stated all resident rooms were daily wiped down, the trash was removed, toiletes were cleaned, and the floors were mopped. He had no cleaning schedule, but said he could remember which rooms needed to be cleaned. *He stated: -All resident rooms were deep cleaned once a week and that included wiping down the walls	F 880		

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F 880	Continued From page 31 from the ceiling to the floor, cleaning windows, and washing the divider curtains. -Lately there had not been a schedule available on what rooms needed to be deep cleaned for that day or the week. -He would deep clean a room if he saw it needed a deep cleaning. 3. Observation on 11/7/24 at 9:15 a.m. of the laundry room revealed: *There was a large amount of gray dust build-up on the pipes and flat surfaces throughout the laundry room. *There were two washing machines and washer number two had a sign that read, "needs repaired." -Washer number one was in use, and had a leaking hose that was dripping onto the floor behind the washer causing curled up, corroded, floor tiles that exposed the cement to water build-up. *The handwashing sink had a PVC (plastic) pipe that came out of the ceiling and was dripping a watery liquid into the sink. There was an orange-colored build-up where the water ran down into the sink. 4. Observation on 11/7/24 at 9:20 a.m. of the clean utility room on the secured unit revealed a laundry basket full of various shoes and slippers that had visible unidentified stains on their surfaces. That basket was sitting on the floor next to shelving that contained clean linens and room dividers. Interview on 11/7/24 at 9:00 a.m. with housekeeping supervisor G regarding the cleaning of utility rooms, resident rooms, and the laundry room revealed:	F 880		

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F 880	Continued From page 32 *He had been the housekeeping and laundry supervisor for one year. -He had been working every day cleaning rooms, since they did not have enough housekeeping staff. -He stated he had been "working on the floor for the past year." -They were trying to hire more housekeeping staff. *He had no housekeeping schedule for the cleaning of the soiled and clean utility closets, but he tried to have them cleaned and mopped once a week. *He was unable to verify when the soiled utility room was last cleaned. *He stated he had fallen behind on completing the room cleaning schedules for his staff and there was no deep cleaning schedule available. -He stated, "I am not sure deep cleanings are being done, but it is supposed to be once a week." *He stated he used to complete a walk-through inspection of the facility every week, then it became once a month, and lately he had "fallen behind" and had not inspected the facility in about four weeks. *He confirmed the laundry room was not on a cleaning schedule. He was unaware of the washer's leaking hose. -He was not sure why a pipe was draining into the handwashing sink. *After a walk-through of the facility and viewing the above observations, he stated "I agree it [cleanliness of the facility] could be better." Review of the 7/2/24 Administrative Policies regarding housekeeping and laundry revealed: *"Cleanliness is a must for a safe, comfortable, and orderly environment. The activity of our	F 880		

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F 880	Continued From page 33	F 880		

housekeeping and laundry departments has a direct effect on the comfort, morale, and safety of the residents, the staff and our visitors."

Review of the housekeeping and laundry services policies revealed they did not include on how often resident rooms and generalized cleaning should occur.

5. Observation and interview on 11/4/24 at 1:59 p.m. in resident 58's room revealed:
*A brown lift chair was turned around and faced the wall.
*Resident 58 was seated in a different chair.
*She was unsure why the brown lift chair was turned towards the wall.
*She would have liked the brown lift chair turned forward to face her television.
*She would have preferred to sit in that brown lift chair as the chair she was sitting in was not a lift chair.

Interview on 11/4/24 at 3:10 p.m. with certified nursing assistant (CNA) M revealed the brown lift chair in resident 58's room had a soiled spot and it was to be cleaned.

Observation on 11/5/24 at 10:10 a.m. revealed that the brown lift chair had been turned forward, and resident 58 was seated in it in a reclining position.

Observation on 11/5/24 at 4:06 p.m. in resident 58's room revealed:
*The brown lift chair had a fabric covering laid over the top of it.
*When the covering was removed there was a strong odor of urine and a wet stain on the seat of

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F 880	Continued From page 34 the chair. Interview on 11/5/24 at 4:36 p.m. with director of nursing (DON) B and infection preventionist D revealed: *Their expectation of staff was to remove the chair when they had noticed it had been soiled and not to have covered it and left it in the resident's room for the resident to use. Review of provider's revised February 2024 Cleaning and Disinfection of Equipment policy: *"Policy" -"1. CLEANING refers to removal of visible soil (e.g., organic, and inorganic material from objects and surfaces and is normally accomplished manually or mechanically using water with detergents or enzymatic products." -"A. Supplies and equipment will be cleaned immediately after use. Gross blood, secretions and debris will be removed as soon as possible. Cleaning may be done in the resident room or the soiled utility room."	F 880		

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(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
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted on 11/5/24. Avantara Saint Cloud was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at E015 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the	E 015	1. The emergency water supply agreement has been reviewed with the emergency water supply vendor and has been sent to the vendor for an updated signature. 2. All residents are at risk. A full house audit of all emergency and contingency agreements will be completed to ensure all agreements have been reviewed at least annually. This audit will be completed no later than December 22, 2024. 3. All emergency and contingency agreements for subsistence needs will be reviewed at least annually by the Administrator or designee. A master contract list has been created to assist in monitoring annual review dates and tracking.	12/22/24

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

Ashley Altena | Administrator | 12/02/24

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
	435060	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 1 following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to obtain current memorandums of understanding for emergency supplies (emergency water supply). Findings include: Record review on 11/5/24 at 3:00 p.m. revealed documentation for the emergency water supply	E 015	(Continued from page 1) 4. Administrator and/or designee will audit all emergency supply agreements to ensure the agreements are up-to-date . Audits will be completed monthly for 6 months. Results of audits will be discussed by the Administrator, Maintenance Director, or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 015	Continued From page 2 agreement was dated July 1, 2019. The policies and procedures must be updated annually. Interview with the administrator on 11/5/24 at 3:30 p.m. confirmed that finding.	E 015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	**302 ST CLOUD STREET** **RAPID CITY, SD 57701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS recertification survey was conducted on 11/5/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Saint Cloud was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K293 in conjunction with the provider's commitment to continued compliance with the fire safety standards..	K 000		
K 293 SS=B	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exit lighting for 2 randomly observed exit signs (kitchen and south exit from the dining room). Findings include: 1. Observation beginning on 11/05/24 at 1:30 p.m. revealed the exit sign to the exterior of the building from the kitchen had a battery-pack lighting configuration. Testing of the lights at the time of the observation revealed the two lamps were not functioning for the fixture. Interview with	K 293	1. An electrician vendor was contacted and scheduled to come to the facility to fix the exit sign(s) noted to be out of compliance. Mick's Electric worked at the facility on 11/20/24. The following working was completed by the electricians: Troubleshot GFCI and reset the breaker, replaced exit light and troubleshot lost power. 2. All those receiving services are potentially at risk. A full house audit of all Exit Signage was completed upon discovery of the deficiency to ensure all Exit Signage in the facility were working properly. 3. Exit Signage has been added to the preventative maintenance checks. Administrator will provide education to all management team members and to all staff on how to check the Exit Signage and how to report any findings of concern needing repairs. The education will also include the information on regulation K293 for Exit Signage. This education will be completed no later than December 22, 2024.	12/22/24

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

Ashley Altena | Administrator | 12/02/24

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
	435060	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	**302 ST CLOUD STREET** **RAPID CITY, SD 57701**

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K 293	Continued From page 1 the administrator at the time of the observation confirmed those conditions. The deficiency affected two locations required to be provided with a marked and identifiable path of egress.	K 293	(Continued from page 1) 4. Administrator and/or designee will audit 5 exit signage locations in the facility to ensure they are in proper working order. Audits will be completed weekly x4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator, Maintenance Director, or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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
	10667	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD ST RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 11/4/24 through 11/7/24. Avantara Saint Cloud was found not in compliance with the following requirement: S296.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the	S 296	1. The full-time dietary manager has been enrolled in the ServSafe Food Protection Program as of 11/7/24. The class and exam are scheduled to be completed on December 12, 2024. 2. All those receiving services are potentially at risk. An audit of all dietary staff certifications was completed to ensure the proper number of staff have an active ServSafe certification. 3. ServSafe certificates have been added to the electronic employee record system and database. This database will provide alerts when a certificate and/or license is near the expiration date. The Administrator has provided education to the dietary manager on the regulation requirement S296 – Director of Dietetic Services to ensure the dietary manager is aware of the requirements of the position. Administrator, Human Resources Director, and/or designee will review all current staff for current dated certificates for their relevant position on a monthly basis. 4. Administrator and/or designee will conduct auditing and monitoring of ServSafe Food Protection Program certifications for all current dietary staff. Audits will be completed monthly for 6 months. Results of audits will be discussed by the Administrator, Human Resource Director, or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	12/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Altena

TITLE: Administrator

(X6) DATE: 12/02/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10667	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 296	Continued From page 1 residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and job description review, the provider failed to ensure the food services manager (FSM) possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 11/4/24 at 4:45 p.m. with FSM E revealed: *She had not enrolled in or completed the ServSafe Food Protection Program. -There was one cook who had completed the ServSafe Food Protection Program. *FSM E was not aware of the state regulations for the FSM to have also completed that Program. Review of the provider's updated 12/1/19 Director of Dietary Services job description revealed required education and experience for that position included Food Sanitation Certification.	S 296		
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 11/4/24 through 11/7/24. Avantara Saint Cloud was found in compliance.	S 000		