

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA CLARK CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH AVENUE NW , CLARK, South Dakota, 57225	
(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/6/26 through 1/8/26. Avantara Clark City was found not in compliance with the following requirements: F609, F689, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/6/26 through 1/8/26. Areas surveyed included resident safety related to an elopement and resident behaviors. Avantara Clark City was found not in compliance with the following requirement: F689.	F0000	F0609- Reporting Alleged Violations 1. Administrator completed investigation and submitted FRI of possible skin injury on 1/8/26. Resident 2 has since changed to electronic cigarette to prevent further risk of cigarette related injuries. A smoking evaluation for e-cigs was completed on 1/7/26 indicating that he was able to complete smoking with e-cig safely but still requires supervision due to mobility and ability to reach doorbell. 2. Administrator will review 24-hour summary on point click care daily to possibly identify incidents that are reportable and a whole house audit will be completed to review all residents chart to ensure all required incidents have been reported. 2. Administrator will complete all staff training to educate on reporting policy and reporting allegations or suspected abuse/neglect to administrator and/or DON immediately for continued compliance. Any staff not in attendance will receive education by their manager, prior to their next shift worked. 3. Administrator will audit incident reports, risk management and daily report daily x4 weeks, weekly x4 weeks and then monthly x4 to ensure allegations have been reported appropriately. Administrator will present these audits monthly at QAPI for effectiveness and recommendations.	2/22/26
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the	F0609	All residents have the potential to be affected.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rachel Morehouse LNHA	TITLE Administrator	(X6) DATE 2/9/26
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F0609 SS = D	<p>Continued from page 1 alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, interview, and policy review, the provider failed to report to the South Dakota Department of Health (SD DOH) that one of one sampled residents (2) received cigarette burns to his fingers.</p> <p>Findings include:</p> <p>1. Review of resident 2's electronic medical record (EMR) revealed:</p> <p>*His 10/15/25 Brief Interview for Mental Status (BIMS) score was 13, which indicated his cognition was intact.</p> <p>*He did not have a physician's orders to smoke.</p> <p>*He had diagnoses of nicotine dependence and mild vascular dementia (a group of symptoms affecting memory, thinking, and social abilities).</p> <p>*His 10/15/25 smoking evaluation risk assessment indicated:</p> <p>-He was careless with smoking materials.</p> <p>-He was unable to safely light a cigarette.</p> <p>-He was not considered a "safe smoker" and required smoking management and supervision consistent with facility policy and may not have access to smoking material outside of supervised smoking.</p> <p>-He was to wear a smoking apron, be seated under the folding table, and a staff member was to light his cigarette.</p> <p>-He often attempted to smoke cigarettes down to the filter.</p> <p>*His 10/15/25 care plan indicated:</p> <p>-He was to be supervised, wear a smoking apron, and was to use a cigarette holder when he smoked to prevent him from getting burned because he smoked the cigarette down past the filter.</p> <p>-He needed to be pushed up to the table when he smoked due to his history of burns to his feet from dropping ash.</p>	F0609		

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F0609 SS = D	<p>Continued from page 2</p> <p>-At any time if it was determined that he could not smoke safely with the available levels of support and supervision as indicated on his care plan, the resident's individual smoking methods may need to be adjusted.</p> <p>*Resident 2's physician was notified on 1/4/26 that he had cigarette burns to his right thumb that measured "0.7 x 0.6" and right pointer finger that measured "0.7 x 0.4" that were brown and tan in color without signs of infection.</p> <p>2. Observation and interview on 1/6/26 at 4:08 p.m. of resident 2 outside smoking with CNA L revealed:</p> <p>*She put his coat and smoking apron on him, handed him the cigarette, he put it in his mouth, and she lit the cigarette for him with the lighter.</p> <p>*When the cigarette was close to the filter, she encouraged him to put the cigarette out, and when he did not, she removed the cigarette from his hand and put it out for him, and said he typically tried to smoke it close to the filter.</p> <p>3. Interview on 1/7/26 at 3:27 p.m. with administrator A revealed:</p> <p>*She expected resident 2 to use cigarette holders when smoking if that was indicated on his smoking evaluation risk assessment.</p> <p>*They had been out of cigarette holders for about a week, and resident 2 should not have been allowed to smoke without the use of the cigarette holders.</p> <p>4. Interview on 1/8/26 at 3:35 p.m. with administrator A revealed she was not aware that resident 2 had cigarette burns to his fingers and would have reported that to the SD DOH within 24 hours of the incident had she known.</p> <p>5. Interview on 1/8/26 at 4:04 p.m. with registered nurse (RN) E revealed:</p> <p>*If an injury was found on a resident, she would try to determine the cause of the injury, correct it, notify management, the resident's physician, and the resident's family.</p>	F0609		

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F0609 SS = D	Continued from page 3 6. Interview on 1/8/26 at 4:06 p.m. with director of nursing (DON) B revealed she expected the nursing staff to report resident injuries to administration immediately. 7. Review of the provider's 5/14/25 Abuse and Neglect policy revealed: *"Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service." *If abuse/neglect is suspected the facility will: 1. Take immediate steps to assure the protection of the resident(s)... 2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety... 5. Report the investigation findings to all necessary state/and or local agencies and any other identified persons as required by law." **VII. Reporting/Response.... -All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee."	F0609		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent	F0689		

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F0689 SS = E	<p>Continued from page 4 accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, interview, observation, document review, South Dakota Department of Health (SD DOH) facility reported incidents (FRI), and policy review, the provider failed to ensure:</p> <p>*An environment was free of flammable materials where two of two sampled residents (2 and 26) were observed smoking.</p> <p>*Assistive devices were used for one of one 1 sampled resident (2) who used cigarette holders to prevent a burn.</p> <p>*Appropriate supervision for one of three sampled resident (26) while smoking.</p> <p>*Facility exit and interior doors functioned appropriately, and staff were re-educated as stated in the corrective actions in the 11/16/25 and 11/26/25 FRI regarding one of one closed sampled resident (37) who eloped outside and entered a room where chemicals were stored.</p> <p>Findings include:</p> <p>1. Review of resident 2's electronic medical record (EMR) revealed:</p> <p>*His 10/15/25 Brief Interview for Mental Status (BIMS) score was 13, which indicated his cognition was intact.</p> <p>*He did not have a physician's orders to smoke.</p> <p>*He had diagnoses of nicotine dependence and mild vascular dementia (a group of symptoms affecting memory, thinking, and social abilities).</p> <p>*His 10/15/25 smoking evaluation risk assessment indicated:</p> <p>-He was careless with smoking materials.</p> <p>-He was unable to safely light a cigarette.</p> <p>-He was not considered a "safe smoker" and required smoking management and supervision consistent with facility policy and may not have access to smoking material outside of supervised smoking.</p>	F0689	<p>F0689-Free of Accidents/Hazards/Devices</p> <p>1. Smoking area was relocated to patio off of dining room exit. Signs will be placed in smoking area to identify it as the designated smoking area and that flammable materials must be kept away. Signs will be placed in previous smoking area that notify all staff/residents/visitors that it is not a smoking area due to potential for flammable materials in the area. All signs will be in placed on or before 2/22/26.</p> <p>2. All smoking residents smoking evaluations will be audited, by social worker, for proper/timely completion of assessment and identification/notification of staff of assistive devices or supervision required. All smoking residents will have smoking assessment upon admission, quarterly, and as needed to identify possible interventions required for safe smoking. Assistive devices will be provided for all residents identified to require them. Cigarette holders were ordered 12/31/25 and received 1/12/25 for any residents that may require them. Resident 2 no longer requires them or a smoking apron due to switching to an e-cigarette.</p> <p>3. All smoking materials will be locked in med room and all residents that require supervision will be supervised during designated smoking times. MDS coordinator will review and update all residents' care plans, kardex, and CNA assignment sheets to reflect smoking requirements such as assistive devices and/or supervision or other interventions put in place. Administrator will provide education at all-staff inservice that will be held on or before 2/17/26 to educate all staff of current smoking interventions, smoking supervision policy, and updates with smoking location. Staff not present will be educated by their manager prior to their next shift worked.</p>	2/22/26

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F0689 SS = E	<p>Continued from page 5</p> <p>-He was to wear a smoking apron, be seated under the folding table, and a staff member was to light his cigarette.</p> <p>-He often attempted to smoke cigarettes down to the filter.</p> <p>*His 10/15/25 care plan indicated:</p> <p>-All smoking materials were kept at the nurses' station.</p> <p>-He was to be supervised, wear a smoking apron, and to use a cigarette holder when he smoked to prevent him from getting burned because he smoked the cigarette down past the filter.</p> <p>-He needed to be pushed up to the table when he smoked due to his history of burns to his feet from dropping ash.</p> <p>-At any time if it was determined that he could not smoke safely with the available levels of support and supervision as indicated on his care plan, the resident's individual smoking methods may need to be adjusted.</p> <p>*Resident 2's physician was notified on 1/4/26 that he had cigarette burns to his right thumb that measured "0.7 x 0.6" and right pointer finger that measured "0.7 x 0.4" that were brown and tan in color without signs of infection.</p> <p>2. Interview on 1/6/26 at 3:56 p.m. with certified nursing assistant (CNA) J regarding resident 2 revealed:</p> <p>*Resident 2 smoked twice a day, once in the morning and once in the late afternoon.</p> <p>*His cigarettes were kept locked up at the nurses' station.</p> <p>*He had to wear a smoking apron, and the staff had to go outside with him when he smoked.</p> <p>3. Observation and interview on 1/6/26 at 4:08 p.m. and 1/7/26 at 11:22 a.m. with CNA L in the designated smoking area revealed:</p> <p>*She took resident 2 outside to smoke.</p>	F0689	<p>4. Numerical key pad locks were ordered 1/8/26 and placed 1/26/26 to all doors to areas that residents may not enter safely or pose an elopment risk. The manual entry/exit button was placed in a lock box on 1/8/26 to prevent unwanted entry/exit of front door. Maintenance Director sent request to door security company on 1/9 to have numerical door lock pad repaired so that all staff have the ability to enter door code and monitor entry/exit of front door. Doors are checked daily to ensure door lock and alarm mechanisms are functioning properly. These door checks are logged electronically by the maintenance director, in maintenance software called TELS. Administrator will audit completion of door checks and that the logs are being uploaded timely, weekly x4 weeks, monthly x4, and then quarterly at safety committee metings. The smoking area will be audited weekly x4 weeks, monthly x4 months, and then quarterly x4 quarters to ensure there are no hazardous or flammable materials near smoking area and that previous smoking area is only used as loading/unloading area and there is no smoking being done in unapproved areas. Administrator will bring these audits to QAPI monthly so that audits will be reviewed at QAPI also, for effectiveness and recommendations. All staff and residents have the potential to be affected if these are not adhered to.</p>	2/22/26

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F0689 SS = E	<p>Continued from page 6</p> <p>*The smoking area was just outside the staff entrance door and was in a partially covered area that had a wood privacy panel as a barrier to the area.</p> <p>*She put resident 2's coat and smoking apron on him and handed a cigarette. Resident 2 put it in his mouth, and CAN L lit the cigarette for him with a lighter.</p> <p>*Resident 2 sat at a folding table in the designated smoking area that had two ashtrays on top of it. A snow blower with a closed gas can on the ground beside it was along the interior side of the wood privacy panel, in the designated smoking area.</p> <p>-CNA L verified that the gas can was about half full and was approximately 8 to 10 feet away from resident 2 who was smoking at the folding table.</p> <p>*She encouraged resident 2 to put the cigarette out. When he did not, she removed the cigarette from his hand and put it out for him because he smoked it close down to the filter.</p> <p>*She did not usually take residents out to smoke, and she was not sure how long the gas can had been sitting there.</p> <p>*Staff were to dump the ashtrays out in the red metal trash can that sat next to the building.</p> <p>*She verified there was no signage posted to alert people that that was the designated smoking area or that flammable materials were not supposed to be in that area.</p> <p>4. Interview on 1/7/26 at 11:29 a.m. with CNA M revealed:</p> <p>*She recalled seeing the gas can in the designated smoking area two days prior.</p> <p>*She had received education about fire safety and smoking.</p> <p>*She had not seen any signage in the designated smoking area that identified that it was the designated smoking area or that flammable items were to be kept out of that area.</p> <p>5. Interview on 1/7/26 at 11:39 a.m. with resident 2 revealed he thought the snow blower had been sitting in the designated smoking area for the past few weeks and</p>	F0689		

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F0689 SS = E	<p>Continued from page 7 he did not see the gas can sitting on the ground by it.</p> <p>6. Observation and interview in the designated smoking area on 1/7/26 at 12:04 p.m. with housekeeper N revealed:</p> <ul style="list-style-type: none"> *She and resident 26 were in the designated smoking area, smoking cigarettes. *She thought resident 26 could be outside by himself some days, and other days he needed supervision. *Resident 2 was the only one who needed supervision while smoking. *She thought the snow blower had been outside in the designated smoking area for about a week and saw the gas can sitting by it the day before (1/6/26). *Residents who smoked unsupervised were to ring the doorbell to alert staff when they were ready to come back inside. *Housekeeper N was going back inside, leaving resident 26 unsupervised. <p>7. Observation and interview in the designated smoking area on 1/7/26 at 12:06 p.m. with regional maintenance O revealed:</p> <ul style="list-style-type: none"> *He came to the facility once or twice a month to do the "books, training, and updates." *He used acetone (a flammable cleaning solution) to remove glue from a metal strip while standing about 10 feet away from resident 26, who was smoking. *He was unsure if there was a policy regarding having flammable items near the designated smoking area and thought flammable items should be at least 50 feet away from someone smoking. *He was unsure if a sign needed to be posted that identified the smoking area as the designated smoking area and that flammable items should be kept away from that area. *He verified the acetone can was labeled as extremely flammable and stated he thought he should have been at least 50 feet away from someone who was smoking. 	F0689		

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F0689 SS = E	<p>Continued from page 8</p> <p>8. Interview on 1/7/26 at 12:16 p.m. with maintenance director P revealed:</p> <p>*He worked at the facility for about two years and had not reviewed the smoking policy.</p> <p>*He was unsure if signage needed to be posted in the designated smoking area.</p> <p>*He thought the snow blower and gas can had been sitting in the designated smoking area for about three to four days and that he got busy doing something else and forgot that they were in that area.</p> <p>*He stated it was "common sense" to keep flammable items away from the designated smoking area and the snow blower and gas can should not have been in the designated smoking area.</p> <p>9. Review of resident 26's electronic medical record revealed his 12/18/25 care plan had a focus of: "The resident is a smoker and expresses the desire to smoke at this facility. Currently needs supervision due to his deconditioning from hospitalization."</p> <p>10. Observation on 1/7/26 at 12:20 p.m. of resident 26 revealed that he was outside smoking without supervision. At 12:25 p.m., RN D went outside and then brought resident 26 inside.</p> <p>11. Interview on 1/7/26 at 12:29 p.m. with RN D revealed:</p> <p>*She thought resident 26 had been assessed and was safe to smoke outside without supervision.</p> <p>*She felt he was safe to smoke without supervision.</p> <p>12. Interview on 1/7/26 at 1:05 p.m. with CNA F revealed:</p> <p>*He assisted resident 26 outside to smoke and left him unattended.</p> <p>*He thought that resident 26 had been assessed and was able to smoke without supervision.</p> <p>*When asked where he could find information about resident 26's assessment, he replied that he got the information from his director of nursing (DON).</p>	F0689		

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F0689 SS = E	<p>Continued from page 9</p> <p>13. Interview on 1/7/26 at 1:30 p.m. with DON B revealed:</p> <p>*She felt resident 26 was safe to smoke without supervision.</p> <p>*She stated that resident 26's care plan said that he was not safe to smoke unsupervised, but he would be re-assessed.</p> <p>*When asked how a staff member would know if a resident was able to smoke unsupervised, she said that information is on the "smoke box" (a metal box that holds residents' cigarettes and lighters).</p> <p>14. Observation on 1/7/26 at 1:40 p.m. of the "smoke box" revealed on the inside of the smoke box, a note that read "[resident 4] is the only independent/unsupervised smoker at this time. Both [resident 2] and [resident 26] are to be supervised."</p> <p>15. Review of the provider's CNA sheet revealed it indicated that resident 2 and 26 smoked but did not list any safety measures or if they needed supervision.</p> <p>16. Interview on 1/7/26 at 3:27 p.m. with administrator A revealed:</p> <p>*Smoking assessments were to be completed by the social worker or minimum data set (MDS) nurse. Those assessments indicate if the resident needed supervision while smoking.</p> <p>*The CNA sheet (a document that identifies a resident's care needs and interventions) and the smoke box would indicate if a resident was to have supervision while smoking.</p> <p>*If a resident needed items such as a smoking apron or cigarette extenders to smoke safely that would be indicated in the smoking safety assessment.</p> <p>*Residents were to sit at the folding table in the designated smoking area with their legs under it and be able to reach the ashtray.</p> <p>*They have never had signage posted in that area that indicated it as the designated smoking area and to keep flammable items away from that area.</p>	F0689		

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F0689 SS = E	<p>Continued from page 10</p> <p>*They showed all residents the designated smoking area and told them what the smoking times were during the admission process for all residents.</p> <p>*She was aware they ran out of the cigarette holders last week, and stated that more were ordered on 1/2/26. She expected resident 2 not to have smoked until more cigarette holders arrived.</p> <p>*She was not aware that resident 2 sustained burns on his fingers.</p> <p>*Resident 26 was discharged last month, was readmitted, and last month he was able to smoke without supervision.</p> <p>*When resident 26 was readmitted his smoking assessment indicated he needed supervision for safety.</p> <p>*She expected the staff to supervise resident 26 while smoking.</p> <p>*All residents who smoked had their smoking materials in the smoking box that was located at the nurse's station.</p> <p>*She verified the facility assessment (a mandatory, annual evaluation determining the resources a facility needs to competently care for its residents) did not contain information about the designated smoking area.</p> <p>*She expected that flammable items should not be near the designated smoking area. when not in use.</p> <p>*She verified that having flammable items in or near the designated smoking area was a fire hazard.</p> <p>17. Review of the providers 2/10/24 Smoking policy revealed:</p> <p>**The facility shall establish and maintain safe resident smoking practices while protecting the rights of the individual resident."</p> <p>*...all residents who smoke will be assessed for their ability to safely smoke with or without assistance or supervision and such will be included on the care plan. The Smoking Assessment will be completed at admission, readmission, quarterly, annually, and with a change in condition.</p> <p>Facility will provide staff, family or volunteer</p>	F0689		

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F0689 SS = E	<p>Continued from page 11 supervision when assessment determines supervision is required.</p> <p>The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision."</p> <p>*Designated smoking areas include:</p> <p>...b. Smoking aprons, or devices to assist residents in smoking per assessment findings.</p> <p>The location of the designated smoking area and provisions to ensure residents with the need for supplemental oxygen do not access the area while smoking is taking place."</p> <p>*Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the resident's individual care plan."</p> <p>**The staff shall consult with the Attending Physician and/or the Director of Nursing to determine any restrictions on a resident's smoking privileges."</p> <p>18. Review of the providers facility reported incident (FRI) regarding an incident involving resident 37 on 11/16/25 revealed:</p> <p>*Resident 37 "had been able to exit the building and reviewed security camera footage. At 6pm on 11/16/25, resident 37, was self-propelling wheelchair throughout the facility and exited building unsupervised via a storage area door. Resident left wheelchair, was able to walk to door and push open emergency exit door which shut behind him and he was not able to get back inside. Resident then walked to employee entrance door and knocked on the door where a CNA saw him and assisted him inside."</p> <p>**Resident was outside for a total of 4 minutes."</p> <p>**Maintenance inspected emergency exit door on Monday 11/17 [11/17/25] and saw that a wire had come loose from [the] alarm plug in, causing it not to alarm when opened. Maintenance repaired the wiring in the alarm and the door and alarm are operational again. All exit doors are inspected weekly by maintenance and recorded in TELS [electronic platform to manage building maintenance]. Door check audits will be done daily to ensure the alarm and door remains functioning properly."</p>	F0689		

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F0689 SS = E	<p>Continued from page 12</p> <p>***Point of care charting updated to ensure staff are checking and charting what [this] resident is doing every 30 minutes and CNA assignment sheets have been updated to notify all staff who [which residents] is an elopement risk."</p> <p>**Residents care plan updated to reflect elopement incident and risks. All staff will be re-educated on elopement policy prior to their next shift [worked] and an elopement audit will be conducted for continuance of care amongst all shifts."</p> <p>19. Review of the 11/26/25 FRI revealed:</p> <p>**[Resident 37] (BIMS of a 4) was able to enter [the] housekeeping closet unsupervised and shut the door behind him. He was found by staff at 5:57 p.m."</p> <p>***Per review of the camera footage, the housekeeping closet door was not fully closed after CNA went to find trash bags and pulled the [door] shut but [the] closing mechanism did not close it [the door] fully."</p> <p>***He [resident 37] had just been seen in the hallway at 4:40 p.m. after CNA redirected him from another residents room...."</p> <p>**[Resident 37] has been placed on 1:1 [direct supervision of one resident by one staff member] staff supervision when awake and Foresite system activated when in room until further notice. Foresite fall detection system alerts [the] facility when there is a bed exit or a fall in real time so that staff can intervene promptly. [Resident 37's] care plan has been updated with this intervention. All staff are being educated to ensure all doors are latched when exiting a secured area, to leave key code doors locked when using, and that [resident 37] is to remain on 1:1 staff supervision until further notice. All doors, staff knowledge of elopement policy/procedure, and resident elopement risk assessment will be audited weekly, then monthly...." "The housekeeping door closure was replaced on 11/28 [11/28/25] and is functioning. A daily audit of doors is completed and logged into TELS. Weekend MOD [manager on duty] has been trained on door checks and will report to admin [administrator]/maintenance director for recording."</p> <p>20. Review of resident 37's EMR revealed:</p> <p>*He was admitted to the facility on 7/29/25.</p>	F0689		

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F0689 SS = E	<p>Continued from page 13</p> <p>*His 11/4/25 BIMS assessment score was 4, which indicated he had severe cognitive impairment.</p> <p>*He had diagnoses of Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions).</p> <p>*On admission, his Elopement Risk Evaluation indicated he had a low risk for elopement (leaving the facility without staff knowledge).</p> <p>*A 7/31/26 progress note indicated the resident was admitted to the facility after a hospitalization related to a hip fracture. It also indicated he had been previously at an assisted living memory care unit and prior to that he was at home and was found walking 2.5 miles from his home.</p> <p>*An 8/23/25 progress note indicated the resident wanted to go to his car and find his wife, was agitated, and unable to be redirected.</p> <p>*An 8/29/25 progress note indicated resident 37 would move himself in his wheelchair in and out of other resident's rooms, was agitated, and not able to be redirected.</p> <p>*A 9/7/25 progress note indicated he was agitated and got out of the secured door on the West hall.</p> <p>*A 9/8/25 progress note indicated he pushed the locked egress door until it opened and a staff member closed it before he got out.</p> <p>*On 9/8/25, his Elopement Risk Evaluation indicated he had a high risk for elopement, and a note indicated that he wandered the facility in his wheelchair and pushed on exit doors.</p> <p>*On 10/5/25 a progress note indicated he got out of the alarmed door twice, wandered into other residents' rooms, and wanted to go find his truck or tractor which caused him to be a flight risk and that he had gotten out of the facility several times since he was admitted.</p> <p>*A 10/6/25 progress note by administrator A indicated that she reviewed camera footage and resident 37 opened the front egress door but did not leave the building and staff were in line of sight of him. It also stated that he has never left the building without supervision but had pushed on emergency exit doors while wandering. "(Exit doors are designed to alarm when pushed on and</p>	F0689		

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F0689 SS = E	<p>Continued from page 14 release after continuous pushing for 15 seconds and constant alarm is sounded.)</p> <p>*A 10/10/25 progress note indicated the resident had been exit seeking, and he wanted to find his truck.</p> <p>*An 11/16/25 at 6:09 p.m. progress note indicated that resident 37 was agitated and "made it out inside of the back door (outer door alarmed/secured)."</p> <p>*An 11/16/25 at 11:59 p.m. progress note indicated that he wandered the halls, opened the doors, and kept going behind the nurse's station."</p> <p>*An 11/17/25 progress note indicated the resident's daughter was notified that "resident exited the facility last night through the storage area door. Resident went out the storage area door went over to the employee entrance, knocked and came through the door."</p> <p>*An 11/17/25 Elopement Risk Evaluation indicated the resident had a high risk for elopement.</p> <p>*A progress note on 11/26/25 indicated the resident was found the housekeeping room down the East Hall sitting in his wheelchair between two housekeeping carts. After the resident was removed from the housekeeping room, the staff checked that the door was locked, and it was locked. The administrator was notified. Camera footage was reviewed and found that "CNAs had opened the housekeeping door at 1640 [4:40 p.m.] and left it open, resident propelled [self] into the room at 1648 [4:48 p.m.]. Full staff search started at approx [approximately] 1749 [5:49 p.m.] , and the resident was found at 1758 [5:58 p.m.]. 15 min [minute] checks were initiated and made him [resident 37] a 1:1 staff to resident ratio."</p> <p>*A 12/1/25 progress note indicated that the "1:1 ratio is effective in preventing wandering and reduces fall risks."</p> <p>*His care plan initiated on 7/31/25 stated, "I am an elopement risk as evidenced by: previously leaving my home and being found 2.5 miles away. I have been residing at [facility] Memory Care Unit since May 2025 when this occurred. 9/7/25-wandering in facility in wheelchair and did push on exit door making alarm sound. Was in sight of staff who responded immediately. 11/16/25-attempted elopement."</p> <p>-The goal for that area was, "My safety will be maintained through next review period." -Interventions</p>	F0689		

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F0689 SS = E	<p>Continued from page 15 for that area were:</p> <p>-Initiated on 7/31/25, to "Provide structured activities: toileting, walking inside and outside, recreational activities, music, exercise; reorientation strategies."</p> <p>-Initiated on 11/17/25, to "Offer snacks and diversional activities, looking at magazines, conversation, rummaging activity/items."</p> <p>-Initiated on 11/24/25, to " Offer independent materials as desired, reading magazines and current events, pet visits, music, TV, social and conversation. Normalizing/Purposeful activity candidate: sorting, organizing, tools, tinkering."</p> <p>-Initiated on 11/24/25, for "One-to-one [staff supervision] during all waking hours and redirection interventions include but are not limited to: tinkering/small purpose tasks (screwdriver board, sanding boards, measuring boards, clipboard for taking notes), sorting nuts and bolts, country western music, fidgets, rummage box, coloring, reading newspapers/magazines, picture books, looking at photo albums, reminiscing, socializing/talking, offering snacks."</p> <p>-Initiated on 11/24/25, "Referral made to [facility] memory care unit-placed on waiting list."</p> <p>*After his elopement on 11/16/25 staff were to be checking on and charting what resident 37 was doing every 30 minutes.</p> <p>*After being locked in the housekeeping room on 11/26/25, he was to be on 15-minute checks and to be on 1:1 staff supervision during waking hours, and the Foresite system was to be activated when he was in his room.</p> <p>*He was discharged from the facility on 12/3/25 to a memory care unit.</p> <p>21. Interview on 1/7/26 at 11:29 a.m. with CNA M revealed she received education about elopements a few months ago, was able to explain the elopement process, and had witnessed maintenance check the doors for security.</p> <p>22. Observation on 1/8/26 at 11:04 a.m. revealed there was a button at the front desk, near the front door,</p>	F0689		

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F0689 SS = E	<p>Continued from page 16 that needed to be pushed to let someone exit the front door.</p> <p>23. Observation on 1/8/26 at 11:10 a.m. revealed no one was sitting at the front desk to monitor the green button.</p> <p>24. Review of door audits from 10/12/25 through 1/8/26 revealed:</p> <p>*They were completed daily, however door #7 was not listed as being checked from 10/13/25 through 11/15/25, just doors #1 through #6 were.</p> <p>*All doors were listed as passed the inspection from 11/17/25 through 11/21/25.</p> <p>*There was a note on the 11/17/25 through 11/21/25 door check log book that stated:</p> <p>-On 11/17/25, "#7 door fixed wander guard so it could not be unplugged, also door is marked not an exit."</p> <p>-On 11/21/25, "#7 door is no longer blocked." and "Will have a Dynalock 30 seconds delay as well."</p> <p>-On the 11/17/25 door safety monitoring audit form, a note indicated that the north west (NW) exit door and alarm were not functioning and were to be repaired.</p> <p>-On the 11/18/25, 11/19/25, door safety monitoring audit form, it indicated the NW door were not functioning properly and repairs were pending.</p> <p>-On the 11/20/25 door safety monitoring audit form a note indicated that the north west (NW) exit door did and did not function properly.</p> <p>-On the 11/21/25 door safety monitoring audit form indicated that all doors were functioning properly and were repaired</p> <p>-On the 11/22/25 door safety monitoring audit form it indicated the east and west doors did not function properly because the doors needed to be pulled shut to latch.</p> <p>-The door monitoring log book on 11/22/25 indicated all doors were functioning properly.</p> <p>-On the 11/23/25 door safety monitoring audit form, it indicated that the east and west doors did not function</p>	F0689		

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F0689 SS = E	<p>Continued from page 17 properly.</p> <p>-There was no door safety monitoring audit form for 11/25/26. The door monitoring log book indicated all doors passed on 11/23/25 through 11/29/25.</p> <p>-On the 11/26/25 door safety monitoring audit form it indicated that all doors locked and worked properly and noted that the front door "had to turn key mult. [multiple] times before it relocked and the west door was "difficult to turn key and reset alarm-had to try a different key."</p> <p>-On the 11/29/25 door safety monitoring audit form it stated, "maintenance checked all doors-all functioning properly."</p> <p>-On the 12/6/25 door safety monitoring audit form it indicated that all doors worked properly and a comment stated, " west door-batch sticky".</p> <p>-On the 12/7/25 door safety monitoring audit form it indicated that all doors worked properly and a comment stated, " west hall-key doesn't fit in all the way. Latch got stuck shutting the door. WD40 maybe?"</p> <p>-On 12/7/25 the door monitoring log book indicated all doors passed.</p> <p>25. Observation and Interview on 1/8/26 at 11:08 a.m., 11:17 a.m., 11:22 a.m., and 3:35 p.m. with administrator A revealed:</p> <p>*All exit doors were to be locked and alarmed. They no longer used the WanderGuard system.</p> <p>*Door audits were completed daily.</p> <p>*She completed weekly staff knowledge audits regarding elopements.</p> <p>*Maintenance completed the door audits Monday through Friday, and the manager on duty completed them on the weekends.</p> <p>*Two-door alarms were tested in the hallway where resident 37 had resided and were functioning.</p> <p>*The green button at the front desk needed to be pushed to open the door or staff could use their badge to open it.</p> <p>*If the green button was pushed, it would unlock the</p>	F0689		

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F0689 SS = E	Continued from page 18 front door for three seconds. *After business hours, the button that opened the front door was not always monitored. *She verified that a resident could potentially leave the facility without the staff's knowledge. *Department heads educated their staff regarding elopements. *She verified that 29 staff did not receive education regarding elopements before working their next shift, as indicated in the 11/16/25 Facility Reported Incident report. *It was her responsibility to make sure all education had been completed for all staff before their next shift worked. *All staff should have been educated on the elopement policy, and signed a form once completed. Education regarding door safety was done verbally, and staff signed a form that they received that education. *An elopement risk assessment was not completed after resident 37's second elopement on 11/26/25, and per their policy, it should have been. 26. Review of the providers' 5/14/25 elopement policy revealed: **Each resident will be evaluated upon admission to ascertain elopement risk. Care plan interventions will be initiated based on results....the evaluation will be completed should a resident have an elopement."	F0689		
F0880 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. The facility must establish an infection prevention and	F0880		

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F0880 SS = E	<p>Continued from page 19 control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F0880	<p>F0880- Infection Control</p> <p>1. Policies for EBP, hand hygiene, and infection control were reviewed by admin. All policies were accurate and reflected best practices.</p> <p>2. A whole-house audit will be done for all residents that require EBP are identified, and that policy is followed, all infection control standards are being followed for all residents requiring catheters, lifts are cleaned after each resident, and hand hygiene during medication administration is done correctly. Any deficient practices will be corrected at the time of the audit.</p> <p>2. All lifts were cleaned thoroughly 1/9/26. DON will ensure all lifts and shared equipment will have bags containing sanitizing wipes on them for staff utilizing the equipment can sanitize equipment between residents.</p> <p>3. All staff will receive hand hygiene competency check by their manager at all-staff inservice that will be held on or before 2/17/26. Those not in attendance will have to demonstrate competency prior to their next shift worked. Each department head will be responsible for completing this with their staff. Administrator will audit completion of this education and competency completion weekly x4, monthly x4 and will bring audits to be reviewed at QAPI for effectiveness and recommendations for improvement.</p> <p>4. All staff will be educated on EBP, hand hygiene, catheter care and lift/shared equipment cleaning infection control practices at all-staff inservice that will be completed on or before 2/17/26.</p>	2/22/26

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F0880 SS = E	<p>Continued from page 20 §483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection control practices regarding: *Foley catheters (flexible tubing placed in the bladder to drain urine), tubing and urinary drainage bag placement for two of two sampled residents with foley catheter.</p> <p>*Hand hygiene by one of one registered nurse (RN) D observed administering medications to multiple residents during a noon meal service without sanitizing her hands in between each resident's medication administrations.*One of one certified nursing assistant (CNA) (F) observed without wearing a gown and gloves when transferring a resident (26) on enhanced barrier precautions (EBP), and did not clean the lift after transferring the resident.</p> <p>Findings include:</p> <p>1. Observation on 1/6/26 at 11:25 a.m. of RN D in the dining area administering medications to residents as they were seated for the noon meal revealed she did not sanitize her hands after each administration before preparing medications for the next resident.</p> <p>2. Observation and interview on 1/6/26 at 3:49 p.m. of resident 2 being pushed in his wheelchair to his room revealed:</p> <p>*He was sitting in a wheelchair while CNA J pushed him from the dining room to his room. His urinary catheter tubing dragged on the floor, and he stepped on it numerous times.</p> <p>*CNA J stated she was not aware that the catheter tubing was not supposed to be on the floor and reported it was typical to see it on the floor.</p> <p>3. Observation and interview on 1/6/26 at 2:56 p.m. of</p>	F0880	Administrator will audit hand hygiene during medication administration and infection control practices during catheter cares weekly x4 weeks and monthly x4 months. All staff and residents have the potential to be affected if these are not adhered to.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026
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F0880 SS = E	<p>Continued from page 21 CNAs G and K transferring resident 3 in his room revealed:</p> <p>*He was sitting in a wheelchair with a urinary drainage bag about half full of urine that hung on the wheelchair.</p> <p>*A sign on his door indicated he was on enhanced barrier precautions, meaning gloves and gowns needed to be worn when providing direct care to the resident (EBP).</p> <p>*CNAs G and K put on gowns and gloves, and then used a total body lift (a mechanical lift and sling used to lift a person's full body) to transfer him to his bed.</p> <p>*They hung his urinary drainage bag on the sling, above the level of his bladder.</p> <p>*After lying him in bed his urinary drainage bag was attached to the side of the bed, below the level of his bladder.</p> <p>*CNA G emptied the urine from his urinary drainage bag into a designated container and dumped the urine into the toilet.</p> <p>*They then lowered his bed to the lowest position, and his urinary drainage bag was lying on the floor.</p> <p>*CNA G, using the same gloves, wiped off the mechanical lift with cleaning wipes.</p> <p>*CNA G removed her gloves, left the room with a garbage bag, entered the dirty utility room, exited that room and then sanitized her hands.</p> <p>*CNA G stated she did not receive education that the urinary drainage bag was to remain below the resident's level of the bladder to prevent backflow of urine into the resident's bladder.</p> <p>*CNA G stated that the urinary drainage bag was not supposed to be on the floor without a barrier. She then went to obtain a bin, returned to the room with a bin, and put the urinary drainage bag into it.</p> <p>4. Observation and interview on 1/7/25 at 12:43 p.m. with CNA F revealed:</p> <p>*He was exiting resident 26's room, who was on EBP with a sit-to-stand lift (a manual lift used to assist from a seated to a standing position).</p>	F0880		

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F0880 SS = E	<p>Continued from page 22</p> <p>*He stated he had used a stand lift to transfer resident 26 from his wheelchair to the recliner chair.</p> <p>*He placed the stand lift into room 21, a room with no resident residing in it.</p> <p>*When asked if he wore a gown or gloves while transferring the resident, he responded that he did not because he was not required to wear a gown and gloves when transferring resident 26.</p> <p>*When asked if he cleaned the stand lift after use with resident 26, he replied yes. When no cleaning wipes were seen in resident 26's trash receptacle, he replied that he cleaned the lift in room 21.</p> <p>-There were no cleaning wipes in the trash can of room 21.</p> <p>5. Interview on 1/7/26 at 12:50 p.m. with housekeeper N revealed that she witnessed CNA F did not clean the stand lift after use.</p> <p>6. Interview on 1/8/25 at 12:47 with RN/infection preventionist (IC) C revealed:</p> <p>*She expected staff to sanitize their hands between medication administration to different residents.</p> <p>*She expected staff to follow the facility's EBP policy and to gown and glove when transferring a resident on EBP.</p> <p>7. Review of resident 3's EMR revealed:</p> <p>*His 11/4/25 BIMS assessment score was 9, which indicated his cognition was moderately impaired.</p> <p>*He had a physician's order:</p> <p>-On 3/14/25 for a Foley catheter for urine retention.</p> <p>-On 4/25/25 to irrigate his Foley catheter with 60 ml (milliliter) of sterile water as need for occlusion (blockage).</p> <p>-On 11/19/25 to change his Foley catheter monthly and as needed for occlusion.</p> <p>-On 12/22/25 to change his urinary drainage bag every</p>	F0880		

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F0880 SS = E	<p>Continued from page 23 two weeks and to date the bag.</p> <p>*His 12/2/25 care plan indicated he:</p> <ul style="list-style-type: none"> -Was to be on enhanced barrier precautions (EBP) because he had a catheter. -Had a history of urine retention and urinary tract Methicillin-resistant Staphylococcus aureus (MRSA) (a drug-resistant infection) infection, so staff were to use infection control precautions when dealing with his urine. <p>8. Review of resident 2's EMR revealed:</p> <p>*His 10/15/25 BIMS score was 13, which indicated his cognition was intact.</p> <p>*His 10/15/25 care plan indicated:</p> <ul style="list-style-type: none"> -He had a long-term Foley catheter for chronic urinary retention with a goal to remain free from catheter-related trauma. -He required EBP because he had a Foley catheter. <p>*He had a physician's order:</p> <ul style="list-style-type: none"> -On 4/1/25 to flush his Foley catheter with 60 cc (cubic centimeter) of sterile water to prevent blockages. -On 8/27/25 to change his Foley catheter monthly. -On 11/10/25 to change his urinary drainage bag every two weeks and to date the bag. <p>*His EMR progress notes revealed:</p> <ul style="list-style-type: none"> -On 6/30/25, his physician was notified that he had a large amount of mucous and sediment in his urine with a malodorous smell that was clogging his catheter, and an order for a urinary analysis (UA) was received. -On 7/27/25, resident's physician was notified he had purulent discharge from his urethra for a few days and foul-smelling urine, and an order for UA was received. -He had a UA collected on 7/30/25, and per the lab report his urine culture grew out Proteus mirabilis, Enterococcus faecalis, and stated that multiple microflora were present (which could represent 	F0880		

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F0880 SS = E	<p>Continued from page 24 contamination of the urine sample), and to recollect the specimen if urine culture was clinically indicated. His physician ordered for him to receive Rocephin by intramuscular injection (IM) daily for seven days on 8/4/25.</p> <p>-On 8/21/25, the physician notified the facility of urine culture results that grew out Pseudomonas Aeruginosa infection and ordered Augmentin (an antibiotic) 875 mg by mouth twice daily for three days.</p> <p>9. Interview on 1/8/26 at 3:16 p.m. with director of nursing (DON) B revealed:</p> <p>*They did not have a bladder irrigation policy.</p> <p>*She acknowledged that resident 2 had frequent urinary tract infections.</p> <p>*She expected the staff to keep urinary drainage bags below the level of the resident's bladder and off the floor.</p> <p>*She expected the resident's Foley catheter tubing to be off of the floor.</p> <p>*She expected the staff to remove their dirty gloves before cleaning mechanical lifts.</p> <p>*She expected staff to wash their hands after removing their gloves, when leaving a resident's room, and not to touch the keypad on the dirty utility room door with uncleaned hands.</p> <p>10. Review of the provider's 5/15/25 Enhanced Barrier Precautions policy revealed:</p> <p>**Enhanced Barrier Precaution (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities."</p> <p>**Multi Drug Resistant Organism (MDRO) are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent (e.g., MRSA, VRE), these pathogens are frequently resistant to most available antimicrobial agents."</p> <p>**ENHANCED BARRIER PRECAUTIONS should be used for all</p>	F0880		

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F0880 SS = E	<p>Continued from page 25 resident or for those residents colonized/infected with a novel or targeted MDRO, when they no longer meet requirements for Contact Precautions:"</p> <p>**a. Gowns and Gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing: Dressing, Bathing/showering, transferring, providing hygiene, changing linen, changing briefs or assisting with toileting, device care or use of a device, as listed above, wound care."</p> <p>11. Review of the providers 2/21/25 Catheter Care policy revealed:</p> <p>*The purpose of this policy is to prevent urinary catheter-associated urinary tract infections."</p> <p>**...the urinary drainage bag should still be positioned lower than the bladder to promote proper drainage."</p> <p>**Be sure catheter tubing and drainage bag are kept off the floor."</p> <p>12. Review of the provider's 5/15/25 Hand Hygiene policy revealed:</p> <p>**This facility considers hand hygiene the primary means to prevent the spread of infections. Hand Hygiene is part of Standard Precautions."</p> <p>**All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."</p> <p>**In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub....</p> <p>a. Before and after direct contact with residents</p> <p>b. When entering and leaving a Resident care area/room</p> <p>c. Before donning [putting on] and after removing gloves...</p> <p>e. Before preparing or handling medications."</p> <p>**Hand hygiene is always the last step after removing and disposing of personal protective equipment."</p>	F0880		

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026
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E0000	<p>Initial Comments</p> <p>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 1/6/2026. Avantara Clark City was found in compliance.</p>	E0000		
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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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rachel Morehouse	TITLE LNHA	(X6) DATE 02/07/2026
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026
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K0000	INITIAL COMMENTS A recertification survey was conducted on 1/6/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Clark City was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211, K345, K522, and K911 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0211 SS = B	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain egress requirements by keeping a table and chair in front of the dining room marked exterior exit. Findings include: 1. Observation on 1/6/26 at 10:19 a.m. revealed the marked exterior EXIT from the dining room had a resident dining table and chair situated directly in the path of egress to the door. The table and chair obstructed access to the door. Interview with the maintenance director at the time of the observation confirmed those findings. The table and chair were relocated during the survey. The deficiency affected one of numerous requirements	K0211	K0211-Immediate corrections were made to relocate dining room tables to ensure a clear exit path to exit door on 1/6/26. Monthly audits will be conducted to monitor compliance with the revised seating arrangement and ensure that all exit paths and doorways remain clear and accessible at all times. Audits will be reviewed at QAPI for effectiveness and recommendations. Fire exit pathways and routes will be reviewed quarterly at safety meetings as well. Staff members will receive education at all staff inservice on 2/13/26. Those not in attendance will be educated prior to their next shift worked to maintain compliance with regulatory standards. All staff and residents have potential to be affected.	2/22/26

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rachel Morehouse, LNHA	TITLE Administrator	(X6) DATE 02/01/2026
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K0211 SS = B	Continued from page 1 for egress.	K0211		
K0345 SS = C	<p>Fire Alarm System - Testing and Maintenance</p> <p>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the provider failed to maintain the fire alarm system as required. Existing heat detectors were no longer UL listed for use and could not be certified.</p> <p>Findings include:</p> <p>1. Record review on 1/6/26 at 11:36 a.m. revealed the annual fire alarm report dated 6/25/25 noted 50 existing button-type heat detectors that were no longer UL listed in the building. The building was completely sprinklered and did not require the heat detectors to be installed. The heat detectors would need to be replaced with UL listed devices or removed.</p> <p>Interview with the maintenance director at the time of the record review confirmed that finding.</p> <p>The deficiency affected one of numerous requirements for the fire alarm system.</p>	K0345	<p>K0345-</p> <p>1. Heat detectors are no longer required and will be removed. Maintenance Director requested removal of all devices from Western States Fire Protection on 1/9/26. WSFP to contact administrator and/or maintenance director with date that this task will be completed.</p>	2/22/26
K0522 SS = B	<p>HVAC - Any Heating Device</p> <p>CFR(s): NFPA 101</p> <p>HVAC - Any Heating Device</p> <p>Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also:</p> <p>* is chimney or vent connected.</p>	K0522		

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K0522 SS = B	<p>Continued from page 2</p> <p>* takes air for combustion from outside.</p> <p>* provides for a combustion system separate from occupied area atmosphere.</p> <p>19.5.2.2</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the provider failed to maintain combustion air for the gas-fired laundry dryers.</p> <p>Findings include:</p> <p>1. Observation on 1/6/26 at 10:11 a.m. revealed the exterior 12 inch by 12 inch louver providing outside air for combustion for the two gas-fired laundry dryers was blocked off with a towel and hinged piece of pressed board material.</p> <p>Interview with the maintenance director at the time of the observation confirmed those findings. He stated the room would get too cold in the winter with the direct opening to the outside for fresh air.</p> <p>The deficiency affected one of numerous requirements for combustion air.</p>	K0522	<p>K0522-</p> <p>1. Immediate interventions included: removing foreign objects from vent opening and ensuring proper air ventilation was achieved on 1/6/26.</p> <p>2. A new vent/chimney will be contracted and installed according to NFPA 101 recommendations. All heating devices will be audited by administrator or designee monthly to ensure air flow is not impeded.</p> <p>Audit findings will be reviewed at monthly QAPI and quarterly at safety committee meetings. All staff and residents have the potential to be affected.</p>	2/22/2026
K0911 SS = B Bldg. 01	<p>Electrical Systems - Other</p> <p>CFR(s): NFPA 101</p> <p>Electrical Systems - Other</p> <p>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Chapter 6 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the provider failed to maintain required clear space for electrical panels in the boiler room.</p> <p>Findings include:</p> <p>1. Observation on 1/6/26 at 10:04 a.m. revealed the DP,</p>	K0911		

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K0911 SS = B Bldg. 01	Continued from page 3 MDP, and M electrical panels in the boiler room had items kept in front of them. A vacuum cleaner, bed rails, electrical cords, and a humidifier were on the floor directly in front of the panels. The floor had been marked with yellow paint to show the space that needed to be kept clear. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for electrical equipment maintenance.	K0911	K0911- Immediate intervention included removal of items blocking panels completed on 1/8/26. Floor is marked with reflective tape and painted solid red to clearly identify perimeter and maintenance director educated on regulation. All spaces will be audited monthly for compliance and reviewed monthly at QAPI and quarterly at safety committee meeting. All staff and residents have the potential to be affected.	2/17/26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2026
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NAME OF PROVIDER OR SUPPLIER AVANTARA CLARK CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH AVENUE NW CLARK, SD 57225
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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/6/26 through 1/8/26. Avantara Clark City was found not in compliance with the following requirement: S206.	S 000	S206- Personnel Training 1. Employee H completed all assigned training on January 30th, employee G completed assigned training on February 1st.	2/22/26
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs.	S 206	2. All training plans and onboarding training have been reviewed to ensure all required topics are included in onboarding training. All required topics are up-to-date and assigned to all newly hired staff automatically. Depending on the role of the newly hired staff, the bundle assigned varies from 30-40 topics relative to their department. All staff will be scheduled time to come to facility upon hire to complete onboarding at facility instead of completing at home to ensure that training is completed in 30 day time frame prior to working on the floor. 3. All new hire training, mandatory onboarding bundles, will be audited by administrator and/or HR weekly x4 weeks, monthly x4. These audits will be brought to QAPI and reviewed in HR section of meeting monthly to be reviewed for effectiveness and recommendations. All staff and residents have potential to be at risk.	

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

TITLE

(X6) DATE

Rachel Morehouse, LNHA

Administrator

02/07/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA CLARK CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH AVENUE NW CLARK, SD 57225		
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S 206	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, employee training record review, interview, and policy review, the provider failed to ensure that two of three newly hired employees (G and H) reviewed completed the required orientation training within 30 days of their hire date.</p> <p>Findings include:</p> <p>1. Review of employee personnel records revealed: *Employee G was hired on 8/21/25 as a certified nursing assistant (CNA). *Employee H was hired on 9/24/25 as a licensed practical nurse (LPN).</p> <p>2. Review of CNA G's employee training records revealed she did not complete the required training within 30 days of her hire date regarding the topics of: *Advanced directives. *Proper use of restraints. *Dining assistance, nutritional risks, and hydration needs of residents. *Abuse and neglect. *Fire prevention and response. *Emergency procedures and preparedness. *Infection control and prevention. *Accident prevention and safety procedures.</p> <p>3. Review of LPN H's employee training records revealed she did not complete the required training within 30 days of her hire date regarding the topics of: *Fire prevention and response. *Emergency procedures and preparedness. *Infection control and prevention.</p>	S 206		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2026
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S 206	<p>Continued From page 2</p> <ul style="list-style-type: none"> *Proper use of restraints. *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *Accident prevention and safety procedures. *Care of residents with unique needs. *Dining assistance, nutritional risks, and hydration needs of residents. *Abuse and neglect. *Advanced directives. <p>4. Interview on 1/8/26 at 1:39 p.m. with business officer manager (BOM) I revealed:</p> <ul style="list-style-type: none"> *The provider used an online training program (Relias) for employee-required training. On 9/1/25, the provider switched the training program from Relias to another online training program called "SNF Clinic." *Employees hired during the transition may have started their mandatory orientation training in the Relias program and completed their training in the SNF Clinic program. *She was unsure if CNA G and LPN H had completed all of the required training topics within 30 days of their hire date because all trainings were assigned through their corporate office. <p>5. Interview on 1/8/26 at 2:19 p.m. with administrator A revealed:</p> <ul style="list-style-type: none"> *The provider switched the online training program for newly hired employees in September 2025. *It was difficult getting all the required training assigned during the transition from the Relias program to the SNF Clinic program. *She confirmed that CNA G was hired on 8/21/25 and completed three required topics in the Relias program. The remaining required topics were assigned on 10/1/25 in the SNF Clinic program and were not completed within 30 days of CNA G being hired. 	S 206		

South Dakota Department of Health

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S 206	<p>Continued From page 3</p> <p>*She confirmed that LPN H was hired on 9/24/25 and all the required training topics were assigned to her in the SNF Clinic program on 10/4/25, and she did not complete those required trainings within 30 days of being hired.</p> <p>*She tracked the completion of required orientation training to ensure it was completed within 30 days of the employee's hire date. She thought that these had been missed during the transition.</p> <p>*She expected all required orientation training to be completed within 30 days of being hired and annually by all staff members.</p> <p>6. On 1/8/26 at 12:52 p.m., administrator A was requested to provide a policy on annual and new employee training. A revised 1/1/26 Compliance Plan was provided. The Compliance Plan did not address annual or new employee training requirements.</p>	S 206		