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	435039	A. BUILDING _______ B. WING _______	C 06/20/2024

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AVANTARA NORTON	**3600 SOUTH NORTON AVENUE** **SIOUX FALLS, SD 57105**

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/19/24 through 6/20/24. Areas surveyed included Accident Hazards related to wheelchair pedals, Quality of Care/Treatment related to a resident death, and Abuse/Neglect related to an incident between a resident and a staff member. Avantara Norton was found to have past noncompliance at F550 and F609.	F 000		
F 550 SS=G	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 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.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Nickel
TITLE: LNHA
(X6) DATE: 06/28/2024

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 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 the South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to honor a resident's refusal to shower and to follow that resident's bathing preferences as directed on their care plan for one of one sampled resident (1). Failure to do so resulted in the resident expressing feelings of anger and mistrust towards a staff member. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's SD DOH FRI submitted on 5/28/24 at 11:22 a.m. revealed: *Resident 1 reported certified nurse aide (CNA) E was rough with her on the morning of 5/27/24. *She reported that CNA E "forced her to wake up at 7:10AM and demanded she take a shower because she urinated on herself," and "grabbed her by the arms and pushed her down into the	F 550	Past noncompliance: no plan of correction required.	

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chair."

2. Interview on 6/19/24 at 1:36 p.m. with resident 1 regarding the above incident revealed:
*A staff member came in her room around 7:00 a.m. and woke her up.
*She had not seen that staff person before.
*The staff person startled her and was tried to tell her to get up to take a shower.
-She asked the staff person who she was.
-She said the staff person said, "I don't work here, I'm just a temporary."
*The staff person grabbed her by both arms and slammed her down in the shower chair.
-Resident 1 said that she told the staff person to "get your hands off me or I'm going to deck you."
*She said that she was "manhandled."
*She said her shoulders were hurt because that staff person grabbed her.
*She did not like to wake up that early and would rather have gotten up around 8:00 a.m. or 9:00 a.m.
*She went to physical therapy after that incident and told the therapist about the situation. She thought that the therapist informed the "head therapy gal."
*Her son visited that morning, and she also told him about the incident.
-Her son immediately informed the "manager" about the situation and demanded that that CNA was not to go into his mother's room anymore.

3. Interview on 6/19/24 at 2:58 p.m. with physical therapy assistant (PTA) H and physical therapist (PT) I regarding resident 1 revealed:
*PTA H confirmed he was present on the day of that incident.
*He remembered resident 1 having had mentioned "being upset about not wanting to get

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up that early to shower."
*He did not recall her saying anything about being manhandled.
*PT I indicated if a resident concern was serious enough like this incident described, they would have reported it to administrator A or director of nursing (DON) B.
*Neither of them reported resident 1's concern to anyone.

4. Interview on 6/19/24 at 4:25 p.m. with resident 1 regarding the above incident revealed:
*She did not recall having been incontinent that morning.
*She said, "I may have piddled" because she was startled.
*She did not believe she was soaked with urine that morning.
*She said in regards to having been awakened for bathing, "It made me mad, first fucking thing in the morning."

5. Interview on 6/20/24 at 9:05 a.m. with CNA G regarding the above incident revealed:
*She confirmed she was working that day.
*She remembered hearing about the situation but had not witnessed it.
*Resident 1 did not always like to shower, especially in the morning.
*She confirmed she worked with CNA E that day and did not have any concerns with how CNA E had interacted with other residents.
*She confirmed CNA E worked the entire shift from 6:00 a.m. to 6:30 p.m.

6. Interview on 6/20/24 at 9:18 a.m. with licensed practical nurse (LPN) D regarding the above incident revealed she:
*Confirmed she was working that day.

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F 550	Continued From page 4 *First learned of the incident when the resident's son came to her that morning and told her that he did not want CNA E involved in his mother's care going forward. *Spoke to resident 1 and she told her CNA E had "came in and hoisted her." *Said that resident told her she had reported the incident to PTA H earlier. *Recalled feeling frustrated about the situation because neither PTA H nor CNA E had told her about the incident. *Helped resident 1 with filling out a grievance form on 5/27/24 and gave that form to the manager on duty, LPN C, and texted administrator A that same day to let her know about the incident. *Told CNA E not to go into resident 1's room or answer her call lights anymore that day. *Indicated that day was her first time working with CNA E, but she was "great at getting her job done" and reported no other concerns with CNA E's demeanor. *Spoke with PTA H and "reminded him to let them know if a resident tells [him] anything like that." *Confirmed that LPN C was on site that day from about 8:00 a.m. to around 4:00 p.m. 7. Interview on 6/20/24 at 10:49 a.m. with CNA E regarding the incident between her and resident 1 revealed: *She signed up for a full shift on 5/27/24. *They were "overscheduled" that day, so she was reassigned to help with showers in the rehabilitation (rehab) unit. *She had never worked on that unit before, and she did not know those residents. *She was not briefed on who the residents were, if they needed help with transferring, or anything directed on their care plans.	F 550		

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F 550	Continued From page 5 -She was given a piece of paper with resident names and room numbers on it and was told those residents needed a shower that day. *No one told her that resident 1 did not like to wake up that early in the morning, or that the resident would rather shower in the evening. *Before breakfast that day, she knocked and walked into resident 1's room and introduced herself. -The resident needed to use the toilet. -She placed the resident's wheelchair next to her bed. -The resident was not steady. *She tried to explain to the resident that she needed to shower because her brief and clothes were wet. -She said the resident said to her, "I don't give a fuck about being wet." -She was trying to convince her that "you [resident 1] really need to shower." -Resident 1 said to her again, "I don't want to shower." *She helped the resident undress and transfer to the toilet. *Resident 1 stood up from the toilet suddenly and looked unsteady, so she placed her right hand on the resident's left arm to guide her to the shower chair to prevent her from falling. *CNA G came in to help. *CNA E informed the nurse about the situation immediately. *She said after that incident, she had helped the resident two more times before the nurse instructed her to not go into resident 1's room anymore. -Resident 1 put her call light on twice after breakfast and was "perfectly sweet." -The resident's son was the one who requested other staff to care for resident 1, not the resident	F 550		

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herself.
*She confirmed she worked the rest of her shift.
*She confirmed that before she started working for the facility, she reviewed an orientation packet that included training on abuse and neglect.
*Either administrator A or DON B contacted her on 5/28/24 to inform her of the investigation process and they would be in touch with her regarding her employment.
*She received a notification from her staffing company that she was put on the "do not return" list for this facility.

8. Interview on 6/20/24 at 12:02 p.m. with LPN C regarding the above incident revealed:
*She confirmed she was filling in as the manager on duty that day.
-She was the only manager in the building that day, and it was a very busy day.
*LPN D had informed her of the situation, but she said her understanding of the situation was resident 1 was "frustrated with being here and had trouble with a CNA transferring her."
*She had instructed LPN D to help resident 1 fill out a grievance form.
*She did not review the grievance form before LPN D had slipped the form under the door of either the social worker or the administrator.
*Her impression of the situation was not "manhandling."
-"If I had been told that there was alleged abuse, I would have called [DON B] or [administrator A] right away."
*Administrator A reeducated her, and the management team, regarding the provider's abuse and neglect policy and when to report incidents.
*She spoke with resident 1 the next day and the resident had not reported any concerns at that

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F 550	Continued From page 7 time. *During shift change, staff were to have reviewed the daily assignments sheets, reviewed diets, special equipment, how residents transfer, and their code status. *Staff were to have a "Kardex" pocket care plan as well. 9. Interview on 6/20/24 at 12:29 a.m. with administrator A and DON B regarding the incident between resident 1 and CNA E revealed: *It was their expectation to have been notified immediately regarding any potential abuse or neglect situations. *Administrator A was notified of the situation through a grievance form on 5/28/24. *She immediately suspended the CNA pending the investigation and spoke with resident 1 regarding the incident. *She spoke with CNA E to obtain her side of the story. *As part of the investigation, she: -Interviewed other residents on the rehab unit to learn if there were any other resident concerns. -Interviewed staff to learn about their involvement. -Informed the director of therapy of the situation so she could educate therapy staff about what to report, when to report, and who to report to. -Reeducated staff from all departments about the provider's abuse and neglect policy and expectations for reporting. *Her expectation would have been to allow resident 1 to refuse the shower and to come back later or have a different staff member come back later to assist the resident. *Administrator A denied she had received a text from LPN D on 5/27/24 regarding the incident. *She informed the staffing agency to not allow	F 550		

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CNA E return to the facility.

10. Review of the grievance form written by LPN D on 5/27/24 revealed:
*The form was filled out at 12:30 p.m.
*LPN D received information from both resident 1 and resident 1's son.
*Under the "Describe Grievance or Satisfaction" section:
-"0700 [7:00 a.m.] - Resident reports that this morning CNA had come in to get her up.
-Resident reports that CNA had put shower chair in front of her and resident had stated 'I don't want a shower this early.'
-CNA then had said 'Well you peed all over yourself.'
-Resident reports that then CNA [picked her] up by both her arms and placed her in shower chair.
-Resident reports that CNA had told her she didn't [work] here and resident had replied 'Well why are you here.'
-Resident also reports that CNA was very rough with her this morning."
*The "Resolution" section read, "Reported to DOH [Department of Health], see investigation Finding in file."

11. Review of the provider's investigation into the incident revealed the following:
*When the administrator received the grievance form on the morning of 5/28/24, she immediately suspended CNA E pending the investigation.
*A skin assessment was completed on resident 1 with no new skin concerns identified.
*The resident expressed her experience through additional interviews.
*Other staff and residents were interviewed regarding CNA E.
-All other residents interviewed verbalized having

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been free from abuse and neglect.
-No new concerns from other staff members were identified.
*CNA E's staffing agency was notified that she was not allowed to return to the facility.
*Resident 1 and her son were informed of the outcome of the investigation and indicated satisfaction with the grievance outcome.
*A complaint was submitted to the South Dakota Board of Nursing regarding CNA E.

12. Review of resident 1's electronic medical record revealed:
*She was admitted on 5/16/24.
*Her most recent Minimum Data Set assessment was completed on 5/22/24.
-The Brief Interview for Mental Status score was 13, indicating she was cognitively intact.
*CNA E documented resident 1 had received a shower on 5/27/24.
-It was documented the resident required "total dependence [of staff]" of "one person physical assist" with the shower.
*The resident's last documented shower before the incident was on 5/23/24 at 1:15 p.m.
*Resident 1 was incontinent of bladder and continent of bowel on the morning of 5/27/24.
*She had physician's orders for the following pain medications:
-"Acetaminophen Oral Tablet 500 MG [milligrams] (Acetaminophen) Give 500 mg by mouth three times a day for Pain don't exceed Tylenol 3gm [grams]/24 hours." That had a start date of 5/22/24.
--On 5/27/24, she reported her pain level at a 0 out of 10 for the three doses administered.
--On 5/28/24, she reported her pain level at a 4 out of 10 at the 9:00 a.m. dose, 7 out of 10 at the 1:00 p.m. dose, and 4 out of 10 at the 5:00 p.m.

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dose.
-"Acetaminophen Oral Tablet (Acetaminophen) Give 650 mg by mouth every 6 hours as needed for pain or fever." That had a start date of 5/16/24.
--She did not take any of the as needed (PRN) acetaminophen between 5/27/24 and 5/31/24.
-"oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 2.5 mg by mouth every 4 hours as needed for pain management until 6/13/24." She did not use the PRN oxycodone during May 2024.

Review of resident 1's care plan at the time of the incident (5/27/24) revealed:
*A focus area that read, "[Resident 1] requires assistance with [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)." Initiated on 5/16/24. Revised on 5/28/24.
-An intervention under that section read, "Assist resident with shower/bathing 2 showers per week in evening." Initiated on 5/16/24. Revised on 5/16/24.
*There was nothing in her care plan at the time of the incident indicating how the resident was to have been transferred.
-An intervention was added on 5/28/24 that read, "[Resident 1] is independent with toileting hygiene and transfers will self-propel in wheelchair without pedals, she will at times remove her foot pedals and will at times remove the bag off the back of the wheelchair for foot pedals." Initiated on 5/28/24. Revised on 6/19/24.

Review of the therapy provider's progress notes revealed:
*Resident 1 received occupational therapy and physical therapy services on 5/27/24.
*The occupational therapist assistant's note read:

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-"Pt [patient] presents supine [laying on her back] in bed and requires supervision to push up into sitting at EOB [edge of bed].
-Pt ambulates to bathroom with use of FWW [front wheeled walker] and transfers onto toilet with use of grab bars with CGA-SBA [contact guard assist-stand by assist] for safety.
-Pt ambulates throughout facility with FWW and CNA and demonstrates ability to ambulate from room to therapy gym."
-There was no mention of the resident's demeanor or any complaints during the occupational therapy session.
*The physical therapist assistant's note read:
-"Patient pleasant and cooperative with no new complaints. Denies any new pains/soreness."

13. Review of the provider's February 2024 Grievances policy revealed:
*Procedure:
-"...2. The facility Administrator has been designated to receive all grievances."
-"...6. During the investigation, the facility will put in place immediate action to prevent potential violation of resident's rights."
-"7. If the grievance includes suspected abuse, neglect, injury of unknown source, or misappropriation of property, abuse protocol will be followed. (See Abuse and Neglect Policy)"
-"Process: Party initiating the comment of Grievances or Satisfaction:"
--"...If there is a grievance that needs immediate attention, please bring it to your charge nurse's attention right away so it can be addressed by the facility Administrator."
--"Some situations that require a more immediate response include but are not limited to:
...situations that could be abuse such as yelling, rough treatment, hitting, etc."

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F 550	Continued From page 12 -"Process: Staff Member:" --"...Submit the forms to the Charge Nurse. Alert the Administrator if immediate action needs to occur." -"Process: Charge Nurse and Management Team Members:" --"...If it is a Grievance, determine if immediate intervention is needed. Alert the administrator if immediate action needs to occur." 14. Review of the provider's February 2024 Abuse and Neglect policy revealed: *"Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. -The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. -These guidelines include compliance with the seven (7) federal components of prevention and investigation." *"Types of Abuse and Examples: Physical -Physical abuse includes but not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poling, twisting, and roughly handling. -Any person in a position of power or authority may potentially cause harm to a resident. Potential aggressors include but are not limited to, facility staff, ...other visitors." *"If abuse/neglect is suspected the facility will: -1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care.	F 550		

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	435039	A. BUILDING ______ B. WING ______	C 06/20/2024

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-2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety.
-3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses.
-4. Notify law enforcement authorities if indicated (i.e., a crime such as physical or sexual abuse, theft, etc.)
-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.
-All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received."
*In section "1150 B" of the policy:
-"Reporting: All allegations and/or suspicions of abuse/neglect must be immediately reported to the facility Administrator or designee in the absence of the administrator.
-Failure of an employee to report an allegation and/or suspicion of abuse will result in disciplinary action.
-The Administrator is the Abuse Coordinator.
-The abuse coordinator must submit a preliminary investigation report to their required state agency immediately once assurances for the resident's or other resident's safety have been established."

The provider implemented actions to ensure the deficient practice does not recur was confirmed after: record review revealed the facility had followed their quality assurance process, provided

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education to all staff working within the facility regarding abuse, neglect, and reporting, and resident's rights, review of those educational materials and staff signature sheets of acknowledgement of that education, and interviews with several staff from various departments including housekeeping, social services, nursing, and therapy revealed staff understood the education provided regarding abuse, neglect, and the reporting process.

Based on the above information, non-compliance at F550 occurred on 5/27/24 when resident 1's right to refuse a shower was not honored when staff gave her a shower after she verbalized she did not want to take a shower, and her previously care planned preferences for showering and bathing were not followed. Based on the provider's implemented corrective actions the deficient practice confirmed during the survey from 6/19/24 to 6/20/24, the non-compliance is considered past non-compliance.

F 609 SS=D Reporting of Alleged Violations F 609
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

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F 609	Continued From page 15 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 alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to immediately report allegations of abuse experienced by one of one sampled resident (1). Failure to immediately report allegations of abuse delayed the reporting and investigation process, potentially putting residents at risk for further alleged abuse. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the SD DOH FRI submitted on 5/28/24 at 11:22 a.m. revealed: *A written grievance form was reviewed by the administrator on 5/28/24. *Resident 1 reported that certified nurse aide (CNA) E was rough with her on the morning of 5/27/24. *She reported that CNA E "forced her to wake up	F 609	Past noncompliance: no plan of correction required.	

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at 7:10AM and demanded she take a shower because she urinated on herself," and "grabbed her by the arms and pushed her down into the chair."

2. Interview on 6/20/24 at 12:29 a.m. with administrator A and DON B regarding the incident between resident 1 and CNA E revealed:
*It was their expectation to have been notified immediately regarding any potential abuse or neglect situations.
*Administrator A was notified of the situation through a grievance form on 5/28/24.
*She immediately suspended the CNA pending the investigation and spoke with resident 1 regarding the incident.
*She spoke with CNA E to obtain her side of the story.
*As part of the investigation, she:
-Interviewed other residents on the rehab unit to learn if there were any other resident concerns.
-Interviewed staff to learn about their involvement.
-Informed the director of therapy of the situation so she could educate therapy staff about what to report, when to report, and who to report to.
-Reeducated staff from all departments about the provider's abuse and neglect policy and expectations for reporting.
*Her expectation would have been to allow resident 1 to refuse the shower and to come back later or have a different staff member come back later to assist the resident.
*Administrator A denied she had received a text from LPN D on 5/27/24 regarding the incident.
*She informed the staffing agency to not allow CNA E to return to the facility.

The provider implemented actions to ensure the

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F 609	Continued From page 17 deficient practice does not recur was confirmed after: record review revealed the facility had followed their quality assurance process, provided education to all staff working within the facility regarding abuse, neglect, and reporting, review of those educational materials and staff signature sheets of acknowledgement of that education, and interviews with several staff from various departments including housekeeping, social services, nursing, and therapy revealed staff understood the education provided regarding abuse, neglect, and the reporting process. Based on the above information, non-compliance at F609 occurred on 5/27/24 when the allegations of abuse were not immediately reported to the administrator or designee, and based on the provider's implemented corrective actions the deficient practice confirmed during the survey from 6/19/24 to 6/20/24, the non-compliance is considered past non-compliance.	F 609		