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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING _____ B. WING _____	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/1/22 through 8/4/22. Avantara Huron was found not in compliance with the following requirement: F689. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/1/22 through 8/4/22. Areas surveyed included participation in planning care, reasonable accommodations of needs, clean and comfortable environment, therapeutic diets, and sufficient and competent nursing staff. Avantara Huron was found in compliance.	F 000		
F 689 SS=G	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 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure proper use of assistive devices resulting in an injury for one of four residents (49). Findings include: 1. Observation and interview on 8/1/22 at 4:35 p.m. with resident 49 revealed she:	F 689	1. The IDT met regarding the care plan interventions for falls for resident number 49 on 8/4/2022. Resident number 49's care plan was updated with all interventions regarding fall prevention, which included that foot pedals are offered to resident number 49 when she is going to be transported by staff. Education regarding the use of foot pedals on resident wheelchairs during transport ws given to C.N.A. L on 8/1/2022. This education was in regards to resident 49's fall on 7/31/22. Education was provided to all staff on 8/2/2022, regarding the use of foot pedals on wheelchairs during resident transports. 2. All other residents in the facility at risk of falls or who have fallen, will be assessed by the IDT on 8/29/2022 and 8/30/2022. Appropriate interventions regarding the use of assistive devices and other fall prevention interventions deemed appropriate for these residents will be care ------continued on next page	08/31/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem
TITLE: Administrator
(X6) DATE: 08/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING _____ B. WING _____	C 08/04/2022

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AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

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F 689	Continued From page 1 *Was seated in a wheelchair in her room facing her bed, rubbing her forehead with her left hand, and breathing out at times through her lips. *Had a large, scabbed area on her upper lip. *When the surveyor asked about having pain and then if the injury on her lip was the result of a fall, the resident nodded her head yes both times to confirm her head hurt and the injured lip happened from a fall. Interview on 8/2/22 at 11:02 a.m. with resident 49's responsible party revealed: *His only comment in response to the surveyor's mention of the recent fall with the injury on her lip was that she had a history of falling. *He believed they were treating her for pain management. Observation and interview on 8/3/22 at 9:40 a.m. with resident 49 revealed: *She was in her room with the door closed, seated in her wheelchair facing her bed, rubbing her forehead with her left hand, and breathing out at times through her lips. *She used her feet to wheel back and forth slightly until she locked her wheelchair brakes. *When surveyor asked: -What were her plans for the day, she pointed to her bed. -How do you call staff for assistance to get into bed, she turned her wheelchair around, headed to the bathroom door and opened it, reached into the bathroom and turned on the call light. -The bedside call light was within reach on the lounge chair next to her bed. Interview on 8/3/22 at 9:50 a.m. with certified nursing assistant (CNA) K after she responded to resident 49's call light, revealed:	F 689	planned following the assessments at that same time. 3. The Administrator, Director of Nursing, and IDT reviewed and revised the facility policy regarding the use of assistive devices and implementing other fall prevention interventions along with care planning of those interventions mentioned above for all residents identified at risk for falls or who have fallen. The Administrator, Director of Nursing, and IDT members educated all staff at a mandatory All-Staff meeting on 8/24/2022. This education included review of the cited deficiency, the policy regarding use of assistive devices during resident transports, updating care plans related to the use of assistive devices, and reviewing appropriate interventions for residents identified at risk for falls or who have fallen. Additionally, education on the roles and responsibilities of staff members in assisting residents identified at risk for falls and the use of assistive devices during resident transports. Those staff members not in attendance at the staff meeting due to working the floor, illness, vacation, or casual work status, will be educated prior to their shift upon their return to work. 4. The Director of Nursing will be responsible for overall compliance and will restart foot pedal audits on resident 49 and 5 other random residents weekly for 4 weeks and then monthly for 3 months to ensure compliance. The Director of Nursing/designee will be conducting these audits. The Director of Nursing/designee will also conduct fall prevention care plan audits on resident 49 and 5 other random residents at risk for falls to ensure fall risk prevention interventions are being following appropriatley. -----continued on next page	

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	435020	A. BUILDING _____ B. WING _____	C 08/04/2022

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F 689	Continued From page 2 *She seemed to use the bathroom call light more than her bedside one. *She liked to lie down in bed most of the time. *She did not speak very much. *Her injury was from a fall, but CNA K was not working on that day. Review of the provider's report completed by director of nursing (DON) B and submitted to the South Dakota Department of Health (SD DOH) revealed: *The fall event occurred on 7/31/22 at 3:40 a.m. *The initial report, submitted on 7/31/22 at 4:14 a.m. to the SD DOH noted: -Resident 49 "was witnessed falling forward out of her wheelchair." -CNA L "was pushing [resident name] in her wheelchair...causing [resident name] to fall on the floor." -"Staff member reports she believed that [resident's name] feet went underneath the wheelchair." -The "Charge nurse conducted a head-to-toe assessment" and found a "laceration to her upper lip and was missing one and a half of her teeth." -[Resident name] "reported she was having pain...Nursing assessment revealed 9 of 10 on painad (sic) scale." *The final report, submitted on 8/2/22 at 8:52 a.m. to the SD DOH noted: -[Resident name] returned from the emergency room with "no acute fractures or bleeds. Sutures were applied to [resident's name] upper lip with orders to follow up with dentist and PCP (primary care physician) in a few days." -CNA L "was questioned...and it was founded that [CNA L] did not have wheelchair pedals on [resident's name] wheelchair when she was pushing her in the hallway."	F 689	These audits will be conducted weekly for 4 weeks and then monthly for 3 months to ensure compliance. These audits are part of a PIP created through the QAPI process on 8/24/2022. All audit findings listed above will be presented by the Director of Nursing at monthly QAPI meetings for 4 months for discussion of the effectiveness of the correction plan, for recommendations to adjust the correction plan, reduce frequency of the audits, or discontinue the audits based on the audit findings.	

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F 689	Continued From page 3 -DON B provided education to CNA L and planned to "complete audits weekly x [times] 4 weeks to ensure [CNA L] has wheelchair pedals on wheelchairs prior to assisting with locomotion along with 5 random residents weekly x 4 weeks." Review of resident 49's care plan interventions with the dates they were initiated and revised revealed: *No reference to the use foot pedals when transporting the resident in her wheelchair. *Most interventions to keep her "free from fall related injury" had not been updated based on the most recent assessments. *To "maintain my current self care and mobility status" her wheelchair was equipped with "anti roll back brakes - [resident name] is able to self propel." Date initiated 3/06/20, revised 4/05/22. Review of the 4/1/22 significant change Minimum Data Set (MDS) assessment revealed resident 49: *Demonstrated moderate difficulty with orientation to year and month and short-term recall. *Needed weight bearing assistance of two persons to transfer and move about [locomotion or transport] on the unit. *Reported having pain in the last five days without stating how frequently. *Received scheduled pain medications and as needed pain medications were "received or offered and refused." *Had two falls without injury and one with an injury since the prior MDS. Review of the 6/16/22 quarterly MDS revealed resident 49: *Demonstrated severe difficulty with orientation to year and short-term recall.	F 689		

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F 689	Continued From page 4 *Continued need for weight bearing assistance to transfer and move about on the unit *Reported having mild pain almost constantly that made it hard for her to sleep at night and limited her daily activities. *Received scheduled pain medications but as needed pain medications was marked as not received, offered, or declined. *Had two falls without injury and one since the prior MDS. Interview on 8/4/22 at 9:38 a.m. with registered nurse/MDS coordinator F revealed: *She had been on vacation when the fall occurred so she could not comment on the circumstances that caused the fall. *She needed to get caught up on making care plan revisions. *She confirmed the importance of foot pedals for residents at risk for not holding their feet up when being transported in a wheelchair but also commented on the risk that foot pedals could cause for residents that move themselves using their feet. Interview on 8/4/22 at 10:15 a.m. with DON B and corporate nurse consultant (CNC) C revealed: *Audits of CNA L had begun. *No comment was offered about the reason CNA L was pushing the resident in her wheelchair rather than letting the resident self-propel the wheelchair. *After the surveyor reported a random observation on 8/3/22 at 12:17 p.m. of receptionist H pushing resident 26 up to the dining room table with her shoes squeaking as they dragged across the floor, CNC C suggested to DON B that the audits should be expanded to include other residents at risk for an event similar	F 689		

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F 689	Continued From page 5 to resident 49. Review of the provider policy, "Falls Management," revealed: *It is the policy of the facility to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence." * The procedures included: -"Assess and review resident risk factors for falls and injuries upon admission, with a significant change in condition, quarterly, annually, or after a fall." -"Implement goals and interventions...based on individual needs and identified risks." -"Communicate interventions to the caregiving teams."	F 689		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 8/1/22 through 8/4/22. Avantara Huron was found in compliance.	E 000		

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

Laurie L. Solem

TITLE

Administrator

(X6) DATE

08/26/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/17/2022
FORM APPROVED
OMB NO. 0938-0391

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

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	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	**1345 MICHIGAN AVENUE SW** **HURON, SD 57350**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/2/22. Avantara Huron was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=D	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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain egress paths free of hazards for one randomly observed exits (north A-wing exit). Findings include: 1. Observation on 8/2/22 at 3:02 p.m. revealed the path of egress for the north end of the A-wing exit had spalling concrete creating abrupt level changes of greater than 1/4 inch within the path of egress. LSC 7.1.6.2	K 211	1. The concrete on the path of egress located on the north end of A wing exit will be removed and replaced. Flatland Concrete Company has been contracted to replace the concrete pad and will complete the work as soon as their schedule permits. 2. All other paths of egress on the facility campus were assessed by the maintenance director and maintenance assistant and found to be in compliance on 8/26/2022. 3. All paths of egress on the facility campus have been included in the facility preventative maintenance program called TELS to ensure that they are assessed monthly for compliance. These monthly assessments will be conducted by the maintenance director/designee. 4. The maintenance director will be responsible for overall compliance and will conduct monthly audits for 6 months to ensure all paths of egress are in compliance. ---continued on nex page	08/31/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Laurie L. Solem

TITLE
Administrator

(X6) DATE
08/26/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2022**

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AVANTARA HURON	**1345 MICHIGAN AVENUE SW** **HURON, SD 57350**

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K 211	Continued From page 1 Interview with the maintenance director at the time of the observation confirmed that condition. He stated he had very recently been made aware of that condition and had not yet been able to address it. The deficiency had the potential to affect 100% of the smoke compartment's occupants.	K 211	Audit findings will be reported by the maintenance director at monthly Safety & QAPI meetings for discussion on the effectiveness of the correction plan, to make recommendations to adjust the correction plan if necessary, to reduce the frequency of the audits, or to discontinue the audits based on findings.	

South Dakota Department of Health

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	10633	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVE SW HURON, SD 57350

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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 8/1/22 through 8/4/22. Avantara Huron was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and testing, the facility failed to provide exhaust ventilation for: *Three D-wing resident toilet rooms (400, 412, and 415). *The two tub rooms between C-wing and D-wing. *The beauty shop. Findings include: 1. Observation and testing on 8/4/22 from 3:12 p.m. to 3:43 p.m. revealed: *Testing of the exhaust inlet in the toilet room of resident room 400 showed it was not functioning. *Testing of the exhaust inlet in the toilet room of resident room 412 showed it was not functioning. *Testing of the exhaust inlet in the toilet room of resident room 415 showed it was not functioning. * Testing of the exhaust inlet in the tub rooms located between the C-wing and D-wing showed they were not functioning. * Testing of the exhaust inlet in the beauty shop showed it was not functioning.	S 157	1. The ventilation system for D Wing (400 wing), C & D tub rooms, and the beauty shop was repaired on 8/25/2022. 2. All other ventilation systems in the facility were checked by the maintenance director and maintenance assistant on 8/25/2022, to ensure they were all in good working condition. All of them were found to be working and in compliance on that date. 3. All ventilation systems in the facility, including the inlet areas, have been included in the facility preventative maintenance program called TELS and will be checked monthly by the maintenance director/designee to ensure they are all working properly and in compliance. 4. The maintenance director will be responsible for overall compliance and will conduct weekly audits for 4 weeks and monthly audits for 3 months to ensure all ventilation systems are working properly. These audits will be conducted by the maintenance director/designee. Audit findings will be reported by the maintenance director at monthly Safety & QAPI meetings for discussion on the effectiveness of the correction plan, to make recommendations to adjust the correction plan if necessary, to reduce the frequency of the audits or to discontinue the audits based on findings.	8/31/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem

TITLE: Administrator

(X6) DATE: 08/26/2022

South Dakota Department of Health

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S 157	Continued From page 1 Interview with the maintenance director at the time of the observations confirmed those conditions. He stated he had a monthly preventative maintenance list for checking exhaust fans. He stated he had been checking the fans on the roof to make sure they were functioning and had not been testing at the inlets.	S 157		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/1/22 through 8/4/22. Avantara Huron was found in compliance.	S 000		