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 11/14/2024

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/12/24 through 11/14/24. Avantara Huron was found not in compliance with the following requirements: F625, F655, F657, F697, F698, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/2/24 through 11/14/24. Areas surveyed included resident neglect, accidents, and physical environment. Avantara Huron was found not in compliance with the following requirement: F600.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI),	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem
TITLE: Administrator
(X6) DATE: 12/06/2024

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 600	Continued From page 1 observation, interview, record review, and policy review, the provider failed to protect residents from neglect by: A. CNA Z who did not provide nighttime cares for one of one sampled resident (425) who was observed the following morning in her clothing from the previous day and incontinent of bowel. Findings include: B. Certified nursing assistant (CNA) (G) who did not provide the appropriate transfer assistance as directed in the care plan for one of one sampled resident (46) who fell. Findings include: A. 1. Review of provider's SD DOH FRI for resident 425 revealed: *At approximately 8:00 a.m. on 8/4/24 resident 425 was "in bed, dressed in the same clothes she had on the day before." She was "incontinent of stool." -A head to toe skin assessment was completed and "reports that all skin is intact, but that her buttocks and peri area are reddened." -Resident 425 "was admitted back to us from the hospital this week and her buttocks at that time was [were] very red and sore." *CNA Z and LPN AA were on duty during the night of 8/3/24. -CNA Z received "disciplinary action and education to follow resident pocket care plans at all times and ensure that all residents get proper bedtime and nighttime cares they require." -LPN AA received "disciplinary action regarding the incident as the charge nurse expectation is to ensure staff follow care plan and ensure residents get proper bedtime and nighttime cares they require." 2. Review of resident 425's electronic medical	F 600		

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F 600	Continued From page 2	F 600		

record (EMR) revealed:
*Her admission date was 10/27/23.
*She was hospitalized from 7/16/24 until 7/30/24 when she returned to the facility.
*Her 6/27/24 Brief Interview for Mental Status assessment (BIMS) score was a 14 ehich indicated her cognition was intact.
*Her 8/5/24 BIMS score was a 99 which indicated she was unable to complete the evaluation.
*Her diagnoses included: depression, macular degeneration (eye disease that cause vision loss), neuropathy (nerve damage), anxiety disorder, post-traumatic stress disorder, lymphedema (swelling of body tissue), reduced mobility, chronic kidney disease, difficulty in walking, need for assistance with personal care, irritable bowel syndrome with diarrhea, and altered mental status.
*She had passed away on 8/29/24.

3. Interview on 11/14/24 at 4:36 p.m. with administrator A regarding the above FRI for resident 425 on 8/4/24 revealed:
*She confirmed their investigation into the incident validated resident 425 was in her bed the morning of 8/4/24 dressed in the same clothes she had on the day before and was incontinent of stool.
*Her expectation was for resident 425's care plan to have been followed.
-Resident 425's care plan had been updated and reviewed upon her return from the hospital.
*After the above incident, all staff were educated on providing appropriate care to residents, and audits of that were being completed.
*FRIs and grievances were reviewed at every QAPI meeting.

4. The provider's implemented actions to ensure

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the deficient practice does not reoccur was confirmed on 11/14/24 after record review revealed the facility had followed their quality assurance process, education was completed, competency of providing care was completed, audits were completed regarding following resident care plans, and observations and interviews revealed staff understood the education provided regarding those topics.

5. Based on the above information, non-compliance at F600 was determined occurred on 8/4/24, and based on the provider's implemented corrective actions on 8/4/24 for the deficient practice confirmed on 8/14/24, the non-compliance is considered past non-compliance.

6. Review of the provider's 2/20/24 Abuse and Neglect policy revealed:
*"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."
*"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 required but fails to provide that service."
B. 1. Review of the provider's submitted SD DOH FRI regarding resident 46 revealed:
*Her Brief Interview for Mental Status (BIMS) assessment score was 5 which indicated she had moderate cognitive impairment.
*On 10/24/24 at 8:10 p.m. the resident fell during

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a stand and pivot transfer with CNA G.
*The resident had a gait belt on and did not acquire any injuries from the fall.
*The resident's power of attorney (POA) and physician were notified of the incident.
*The resident's care plan was reviewed and indicated:
-She was to perform stand and pivot transfers with the use of a gait belt during the day shift with one staff's assistance.
-She was to perform stand-up lift (a mechanical lift used to assist from a seated to a standing position) transfers during the evening and night shift with one staff's assistance.
*Interventions included:
-Education was provided to all staff regarding the importance of following care plans for all residents.
-The resident's "pocket care plan" wording was updated to lessen confusion to staff.
-CNA G as well as four random staff members were to be audited weekly for four weeks to ensure they were following residents care plans.
-Interviews with seven random residents were conducted to ensure staff were following their care plans for transfers.

2. Observation and interview on 11/13/24 at 10:41 a.m. with resident 46 in her room revealed:
*She was seated in her wheelchair watching TV and her call light was within her reach.
*She did not recall any falls that she had recently.
*Her room appeared free of environmental hazards.

3. Observation and interview on 11/13/24 at 2:10 p.m. with licensed practical nurse (LPN) Q revealed:
*There were updated resident care plans located

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F 600	Continued From page 5 at the nurse's station on each hallway called pocket care plans. *The pocket care plans were updated daily if something changes for a resident. *If a staff member is unsure of how a resident transferred, they could look at the pocket care plans for their assigned hallway. *The pocket care plan located in resident 46's hallway indicated she was to be transferred by standing and pivoting with the use of a gait belt and one person's assistance during the day shift and to be transferred with the use of a stand-up lift and one person's assistance during the evening and night shift. 4. Interview on 11/13/24 at 2:15 p.m. with certified medication aide/CNA X regarding how resident 46 transferred revealed: *She was to be transferred by standing and pivoting with the use of her walker and a gait belt. *She would get weaker in the evening which would be when they would use the stand-up lift. 5. Observation on 11/13/24 at 4:10 p.m. with CNA G and resident 46 in her room revealed: *CNA G transferred resident 46 from the toilet to her wheelchair with the use of her walker and a gait belt. Interview with CNA G immediately following the above observation revealed: *CNA G had been working at the facility since April of 2024. *When she was assigned to a hallway, she would get the pocket care plan so she could reference the residents' care needs if she needed to. *She had been with resident 46 when she fell. -She was assisting the resident to bed with a stand and pivot transfer, a gait belt and her	F 600		

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F 600	Continued From page 6 walker when resident 46 said she would not be able to make it. *She lowered the resident to the floor and notified the nurse. *She stated she had misread resident 46's care plan which had indicated she was to be transferred with a stand-up lift during the evening and night shifts. 6. Interview on 11/14/24 at 11:31 a.m. with director of nursing (DON) B revealed education was provided to all staff after resident 46's incident above and audits were being conducted. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/14/24 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding following resident care plans, and observations and interviews revealed staff understood the education provided regarding those topics. Based on the above information, non-compliance at F600 occurred again on 10/24/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 10/26/24, the non-compliance is considered past non-compliance.	F 600		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625	The facility policy - "Discharge and Transfer of Residents/Bed Hold", was reviewed on 12/2/2024 by the administrator, DON, and social service staff, and was deemed appropriate. Education was provided to all Continued on next page.....	12/12/2024

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F 625	Continued From page 7 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to provide bed-hold notice to the resident and/or their representative regarding the transfer to a hospital for one of one sampled resident (5) for two of three occasions. Findings include: 1. Review of resident 5's electronic medical record (EMR) revealed: *He was transferred to the hospital on 12/27/23, 4/23/24, and on 7/6/24. *His representative was notified of resident 5's 12/27/23 transfer and the bed hold policy. *There was no documentation that the bed hold	F 625	licensed nurses and social service staff on 12/4/2024 by the administrator and DON, to ensure that all staff are aware of the facility policy regarding bed holds listed above and to ensure that all residents/families are made aware of this policy at the time of a transfer to the hospital or any other type of resident transfer such as a therapeutic leave transfer of some type. Audits will be conducted on all resident transfers to the hospital or any other type of transfer weekly for 4 weeks and then monthly for 2 months. These audits will be conducted by the social service director/designee. The social service director will be responsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of the correction plan, reduce the frequency of the audits, or discontinue the audits based on the audit findings.	

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F 625	Continued From page 8 information was given to the resident or his representative for the 4/23/24 and 7/6/24 hospital transfers. Interview on 11/15/24 at 4:39 p.m. with social service designee F revealed she was unable to find documentation to support bed hold information had been provided to resident 5 or his representative for the hospital transfers on 4/23/24 and 7/6/24. Review of the provider's undated Bed Reserve Policy Notification revealed: *"This Bed Reserve Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility. *Under normal circumstances, if you leave the facility for a hospitalization, you will be readmitted to the first available bed in a semi-private room. Under certain conditions, we can reserve your existing bed for you at your request, so when you return to the facility, you will have the same bed and room as before." Review of the provider's April 2021 Bed-Hold and Return Agreement revealed the resident, or their representative would be given the opportunity to request a bed-hold and pay a basic per-diem (daily) rate when absent from the facility.	F 625		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655	The facility policy - "Care Plan Policy", was reviewed by the DON, and administrator on 12/3/2024, and deemed appropriate. Residents 10, 23, 46, 49, 55, 64, 65, 67,70, 224, 274, 375, and 424, or their representatives, were offered copies of or to review their baseline care plans on 12/3/24. The baseline care plan for resdient 424 was listed in the 2567 as not signed until 10/29/2024. Resident 424's baseline care continued on next page.....	12-12-2024

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F 655	Continued From page 9 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy	F 655	plan was initiated on 10/25/2024. All new admissions are at risk for baseline care plans not being offered or reviewed with residents or their representatives. All new admissions or re-admissions since the time of the survey have been audited to ensure the resident or their representative has been offered a copy of or a chance to review their baseline care plan. Audits will be conducted weekly times 4 weeks and then monthly for 2 months to ensure baseline care plans are completed timely and are offered or reviewed with residents or their representatives. The DON/designee is responsible for conducting the audits. The DON is responsible for overall compliance and will report audit results at monthly QAPI meetings for 3 months for discussion on 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 655	Continued From page 10 review the provider failed to ensure: *Fourteen of twenty-nine residents (10, 23, 46, 49, 53, 55, 64, 65, 67, 70, 224, 274, 375 and 424) had received a summary of their baseline care plan. *One of one sampled resident (424) had a baseline care plan completed within forty-eight hours of admission. Findings include: 1. Record review of resident 64's electronic medical record (EMR) revealed: *She had been admitted on 1/4/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 2. Record review of resident 65's EMR revealed: *He had been admitted on 3/9/24. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 3. Record review of resident 53's EMR revealed: *He had been admitted on 3/21/24. *There was no documentation in his EMR a baseline care plan summary had been reviewed with the resident or resident's representative. 4. Record review of resident 67's EMR revealed: *He had been admitted on 3/22/24. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 5. Record review of resident 55's EMR revealed: *He had been admitted on 6/11/24. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative.	F 655		

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F 655	Continued From page 11 6. Record review of resident 23's EMR revealed: *She had been admitted on 8/15/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 7. Record review of resident 10's EMR revealed: *She had been admitted on 9/6/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 8. Record review of resident 46's EMR revealed: *She had been admitted on 9/19/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 9. Review of resident 49's EMR revealed: *She had been admitted on 10/8/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 10. Review of resident 70's EMR revealed: *He had been admitted on 10/18/24. *There was no documentation in his EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 11. Review of resident 274's EMR revealed: *She had been admitted on 11/4/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 12. Review of resident 224's EMR revealed: *She had been admitted on 11/5/24.	F 655		

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F 655	Continued From page 12 *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 13. Review of resident 375's EMR revealed: *She had been admitted on 11/7/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. 14. Review of resident 424's EMR revealed: *She had been admitted on 10/25/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident or resident's representative. *Her baseline care plan was not signed as completed until 10/29/24. 15. Interview on 11/13/24 at 4:30 p.m. with social services designee F regarding residents' baseline care plans revealed: *She would have completed the baseline care plan upon admission. *She would not have reviewed the baseline care plan with the resident or the resident's representative. *She had not provided a summary of the baseline care plan to the resident or the resident's representative. *She had been in her position since June 2024 and felt she had not received very much training for her position. 16. Interview on 11/14/24 at 1:38 p.m. with clinical care coordinator registered nurse (RN) C regarding residents' baseline care plans revealed: *She would have reviewed the baseline care plan with the resident or the resident's representative. *She had not been documenting in the resident's	F 655		

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F 655	Continued From page 13 EMR that the baseline care plan had been reviewed with the resident or representative or that a summary of that care plan had been offered. 17. Review of the provider's September 2019 Care Plans policy revealed: *"A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later the 48 hours after admission."	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657	The facility policy - "Care Plan Policy" was reviewed by the DON and administrator on 12/3/2024 and was deemed appropriate. Resident 424's care plan was updated on 11/14/24, to include her change to contact precautions and to include that the family be contacted as a behavior intervention. All other residents with transmission based precautions are potentially at risk. Care plans for all transmission based precautions were reviewed to ensure their care plans included the appropriate type of precaution and all of them are up to date. All residents with behaviors are potentially at risk as well. Care plans for all residents that triggered with behaviors were reviewed to ensure that their behavior care plans are individualized with appropriate interventions. All nurse managers were educated by the DON on 12/4/2024 to ensure that care plans are individualized with appropriate interventions. Audits will be conducted weekly times 4 weeks and monthly times 2 months on resident 424 and four other random resident care plans to ensure that their care plans are individualized with appropriate interventions. continued on next page.....	12-12-2024

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F 657	Continued From page 14 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review the provider failed to ensure the timely review and revision of one of one (424) sampled resident's care plan. Findings include: 1. Observation on 11/12/24 at 4:22 p.m. of resident 424 revealed: *There was personal protective equipment (equipment worn to minimize exposure to a hazard, such as gowns, gloves, face shield and/or masks) (PPE) sign on her door. *There was PPE hanging in a supply caddy on her door. *She had a sign that indicated to check in with the nurse before entering the color of the sign was pink indicating enhanced barrier precautions *She was sitting in her recliner, feet elevated, with Prevlon pressure reduction boots on both of her feet. *A pressure reduction cushion was in her wheelchair. Interview on 11/13/24 at 10:03 a.m. with resident 424 revealed that she: *She was admitted to the facility about three weeks ago. *Her husband also lived in the facility. *She had sores on her feet that she said resulted from her falling and laying on a garage floor for "about two to three days" before she was found. Review of resident 424's electronic medical record (EMR) revealed:	F 657	The DON/designee will be responsible for conducting the audits. The DON will be responsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion of the effectiveness of the correction plan, reduce frequency of the audits, or discontinue the audits based on the audit findings.	

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F 657	Continued From page 15 *She was admitted on 10/25/24. *Her diagnoses include: rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood) and acute kidney failure. *Her nurse progress notes indicated: -She had barricaded herself in her husband's room on 10/26/24 and 10/28/24. -Her family had been called in to help calm her behaviors on 10/26/24 and 10/27/24. Interview on 11/13/24 at 11:46 a.m. with nurse supervisor, registered nurse (RN) S revealed: *She was unable to identify which transmission-based precaution was to be followed when attending to resident 424 by looking at the sign on the door. *She identified that she would look in resident 424's care plan to identify which precautions were to use. Interview on 11/13/24 at 11:58 a.m. with licensed practical nurse (LPN) Y revealed: *She identified that resident 424 was on EBP by the color of the sign on her door. *She stated that resident 424 was on EBP due to her wounds. Review of resident 424's 11/13/24 care plan revealed: *Upon admit she was placed on EBP "related to multiple wounds". *She had a focus area of impaired skin integrity. -Prevalon boots were not listed as an intervention related to her wounds. *She was diagnosed with MRSA on 11/6/24. -Her care plan indicated the "antibiotic therapy related to wound infection with MRSA". -Contact precautions were not added to her care	F 657		

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F 657	Continued From page 16	F 657		

plan with the addition of the MRSA diagnosis.
-EBP remained on her care plan "related to multiple wounds".
*Her admitting diagnosis was Rhabdomyolysis.
-There were no focus areas, goals, or interventions that addressed possible complications related to this diagnosis.
*There was a focus area that identified "barricades self in husbands room".
-There were no interventions for that focus area.
-Her care plan did not address the use of family as an intervention for her behaviors.

Interview on 11/14/24 at 1:38 p.m. with clinical care coordinator, RN C and director of nursing (DON) B regarding resident 424 revealed:
*She was on EBP due to her wounds.
-She was recently diagnosed as being positive for Methicillin-resistant Staphylococcus aureus (MRSA) (a bacteria that is resistant to multiple antibiotics) in one of her wounds.
--That was an indication to advance her precautions from EBP to contact precautions.
-Her care plan was not changed from EBP to contact precautions.
*She had a history of behaviors that involved barricading herself in her husband's room.
-RN C agreed there was no intervention addressed on the care plan related to this.
-Her family had been called multiple times as an intervention to her behaviors.
-RN C agreed the use of family as an intervention for her behaviors was not addressed in her care plan.

Review of the provider's September 2019 Care Plans policy revealed:
* "Individualized, resident- centered care planning will be initiated upon admission and maintained

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F 657	Continued From page 17 by the interdisciplinary team throughout the resident's stay". * "The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations." * "Interventions act as the means to meet the individual's needs." * "Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur."	F 657		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure adequate pain management for one of one sampled resident (375) who expressed she had pain. Findings include: 1. Interview on 11/13/24 at 10:08 a.m. with resident 375 revealed she: *She had asked for medication for pain relief that morning during medication administration time for her pain. *Reported she had pain to the whole left side of her body. *Was told by licensed practical nurse (LPN) L there was no pain medication available.	F 697	The facility policy - "Pain Mangement", was reviewed by the DON and administrator on 12/3/2024, and was deemed appropriate. Resident 375's pain medication was received in the facility on 11/14/24, and nursing staff has continued to monitor this resident to ensure her pain needs have been addressed. All newly admitted residents to the facility are at risk for pain. The DON has requested standing orders that address pain to be available upon admission from providers. Education was provied to all nursing staff by the DON on 12/4/24, on the facility pain policy listed above, to ensure that resident's pain is managed effectively. Audits will be conducted weekly times 4 weeks and monthly for 2 months to ensure all newly admitted residents have pain medication available upon admission. These audits will be conducted by the DON/designee. The DON will be responsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of the correctioin plan, reduce frequcency of the audits, or discontinue the audtis based on the audit findings.	12-12-2024

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F 697	Continued From page 18 2. Review of resident 375's current care plan on 11/8/24 revealed: *She was at risk for pain, she had: -Recently had a right-hand surgery and an incision. -Back pain due to a fall. -Diagnoses of peripheral vascular disease, congestive heart failure, and type 2 diabetes. *A focus area indicated that she was at risk for pain. *The goal for this focus, "states that level of pain is through next review." *The interventions included: *" Evaluate efficacy of pain management." *" Notify MD if inadequate pain relief." *" Provide analgesic as ordered." *"Utilize non-pharmacological intervention (cold/warm wash cloth, massage, distractive activities, reposition, etc.) or ordered analgesic medications. If interventions not effective, then notify MD." 3. Review of resident 375's Electronic Medical Record (EMR) revealed: *She was admitted to the facility on 11/7/24. *Her Brief Interview of Mental Status assessment (BIMS) score was a 9, which indicated she was moderately cognitively impaired. *Her diagnoses included: dorsalgia (pain in the back), gout, postural kyphosis (spinal deformity), peripheral vascular disease, type 2 diabetes mellitus without complications, rhabdomyolysis (muscle tissue break down), pain in left shoulder, pain in left hip, pain in left knee. *A progress note (PN) on 11/13/24 at 2:39 a.m. indicated "Resident 375 complained of pain and requested pain medication." -There was an active order for Tramadol on the medication administration record (MAR).	F 697		

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F 697	Continued From page 19 -She was agreeable to changing positions by moving from her bed to her recliner. -There was no Tramadol in the medication cart. *She had a physician order for "Tramadol (pain medication) 50mg give 1 tablet by mouth every 8 hours as needed (PRN) for severe pain." *There was no documentation that the Tramadol had been administered. *A PN on 11/13/24 at 1:29 p.m. by LPN L indicated "The resident calling out in pain to the bottom while sitting upright in reclining chair. Resident has an PRN order for Tramadol without medication available to issue. LPN L, had called the clinic and awaiting signature from the doctor to have the prescription sent to pharmacy for the medication." *No current order for additional available pain medications indicated in her EMR. 4. Interview on 11/14/24 at 1:39 p.m. with director of nursing (DON) B and clinical care coordinator (CCC) C revealed: *The pharmacy had not received a written prescription from the physician for the Tramadol. *The pharmacy is not able to fill the order until the written prescription is received. *CCC, C confirmed the provider should have followed up with the physician regarding the Tramadol. *Standing orders for additional pain control were not always put in a resident's EMR when they were admitted. 5. Interview on 11/14/24 at 1:00 p.m. LPN L, regarding resident 375's pain revealed: *She had assessed resident 375's pain level and location of her pain on 11/13/24. -She confirmed resident 375 had complained of pain in her bottom.	F 697		

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F 697	Continued From page 20 *She checked resident 375's MAR to see what pain medication the physician had ordered. *She confirmed resident 375 had an order for Tramadol and there was no Tramadol available on the medication cart for administration to resident 375. *She called the clinic and requested the written Tramadol prescription be sent to the pharmacy. *It had been 7 days since the physician had ordered the Tramadol. 6. Observation on 11/14/24 at 3:05 p.m. with LPN L, verified the Tramadol was now available on the medication cart for resident 375. Review of the provider's 3/23/23 Pain Management Policy revealed: *"The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain." *"'Pain Management' is defined as the process that includes the following: a. Assessing the potential for pain. b. Effectively recognizing the presence of pain. c. Identifying the characteristics of pain. d. Addressing the underlying causes of pain. e. Developing and implementing approaches to pain management. f. Identifying and using specific strategies for different levels and sources of pain. g. Monitoring for effectiveness of interventions; and h. Modifying approaches as necessary." *"Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including:" -"Peripheral vascular disease"	F 697		

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F 697	Continued From page 21 *"Pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented." *"Pain management interventions shall reflect the sources, type and severity of pain." *"Strategies that may be employed when establishing the medication regimen include: -"Combining long-acting medications with PRNs [as needed] for breakthrough pain. *"Implement the medication regimen as ordered, carefully documenting the results of the interventions." *"Report the following information to the physician or practitioner:" -"Significant changes in the level of the resident's pain."	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review the provider failed to ensure one of one sampled resident (67) who required dialysis treatment was monitored for abnormalities upon returning from his dialysis treatment. Findings include: 1. Interview on 11/13/24 at 8:40 a.m. with resident 67 revealed: *He received dialysis on Mondays, Wednesdays,	F 698	The facility policy - "Dialysis Management", was reviewed by the DON, and administrator on 12/3/24, and was deemed appropriate. On 11/22/24, orders were entered on all dialysis residents instructing nurses to obtain post dialysis vital signs and enter them into the post dialysis UDA following each dialysis treatment. Education was provided to all licensed nurses on 12/4/24, by the DON, regarding the policy listed above and instructing them to obtain and record vital signs for all dialysis residents following their dialysis treatments. Audits on post dialysis UDA's will be conducted weekly for 4 weeks and then monthly for 2 months on to ensure that vital signs are obtained and documented for all dialysis residents following their dialysis treatments. The DON/designee will conduct these audits. The DON will be responsible for overall compliance and will report audit continued on next page.....	12/12/2024

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F 698	Continued From page 22 and Fridays. *There was a dialysis port located in his chest. -He stated that port went directly to his heart. Review of resident 67's electronic medical record (EMR) revealed: *His admission date was 3/22/24. *His diagnoses included: end stage renal disease, dependence on renal dialysis, heart disease, Parkinson's disease, and cognitive communication deficit. *His physician orders included: -"Dialysis Monday Wednesday Friday." -"REMINDER NURSES: Open and complete 1st section of dialysis UDA [user defined assessment] prior to leaving dialysis and then complete 2nd 2 sections of UDA after dialysis upon return two times a day every Mon, Wed, Fri". *His care plan included "Report significant changes in pulse, respirations and BP [blood pressure] immediately." Review of resident 67's vitals recorded in his dialysis UDA section three Post-Dialysis Evaluation vitals recorded revealed: *His 11/1/24 blood pressure (BP), temperature, pulse, and respirations vitals were documented as his post-dialysis vitals on 11/4/24; and his 10/30/24 oxygen saturations (O2) were documented as his post-dialysis vitals on 11/4/24. *His 10/30/24 O2 was documented as his post-dialysis vitals on 11/6/24. *His 11/6/24 BP, temperature, pulse, and respirations were documented as his post-dialysis vitals on 11/8/24; and his 10/30/24 O2 was documented as his post-dialysis vitals on 11/8/24. *His 11/6/24 his BP, temperature, pulse, and respirations were documented as his post-dialysis	F 698	findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of the plan of correction, reduce the frequency of the audits, or discontinue the audits based on the audit findings.	

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F 698	Continued From page 23 vitals 11/11/24; and his 10/30/24 oxygen saturations were documented as his post-dialysis vitals on 11/11/24. *On 11/13/24 there were no vital signs documented. Interview on 11/14/24 at 2:14 p.m. with registered nurse BB regarding dialysis assessments revealed: *She was aware resident 67 required dialysis. *She had completed the post-dialysis UDA section three that included resident 67's vital signs taken upon his return from dialysis. -Section three vitals should be the vitals when the resident returns from dialysis. *"Ideally" would be done each time. -They "try" to get the CNAs to get the vitals and then the nurse would document. *Confirmed this does not always happen. Interview and record review on 11/14/24 at 4:29 p.m. with director of nursing (DON) B regarding their process for when a resident returned from dialysis was to: *Complete the dialysis UDA, which included: -The amount of fluid removed from the resident during dialysis. -Medications administered during the dialysis treatment. -Obtain the resident's vital signs. --A certified nursing assistant or a nurse could obtain the resident's vital signs. *The nurse was responsible for documenting the vital signs on the post-dialysis UDA. *DON B confirmed resident 67's vital signs documented in his post dialysis UDAs were not always taken the day the assessment was completed. -Her expectation was for the vitals to be obtained	F 698		

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F 698	Continued From page 24 and documented each time a resident would return from their dialysis treatment.	F 698		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to maintain clean and sanitary conditions in one of one observed kitchen where residents' food was stored and prepared. Findings include: 1. Observation on 11/12/24 at 3:30 p.m. of the kitchen revealed: *The walk-in freezer revealed: -There was a form (form 403) on the door of the walk-in refrigerator/freezer titled "Walkin Frig Freezer" where daily temperatures for November were documented.	F 812	1. The facility policies - "Record of Refrigeration Temperatures" and "Food Storage", were reviewed by the administrator, registered dietitian, and dietary manager on 12/3/2024, and were deemed appropriate. Education was provided to all dietary staff by the administrator and dietary manager on 12/4/24 on the policies listed above which includes proper recording of refrigerator & freezer temperatures and to notify the dietary manager or administrator if temperatures out of appropriate ranges so that interventions can be implemented. Those staff members not in attendance at the meeting due to illness, vacations, or casual work status will be educated prior to their shift upon their return to work. The walk in freezer was taken out of service on 11/14/2024 during the survey. A new freezer was purchased and placed in service on 11/15/2024. The diced ham and 2 pies mentioned in the 2567 were destroyed on 11/14/2024. The corn beef hash mentioned in the 2567 was pre-cooked when purchased, so was stored appropriately. continued on nex page.....	12-12-2024

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F 812	Continued From page 25 --It indicated "Code for adequate temperature: Freezer: Not greater than 0 degrees F [Fahrenheit] or food maintained solid. --Daily documented freezer temperatures of the walk-in freezer were recorded chronologically in November were as follows: 12, 15,12, 28, 12, 23, 29, 30, 2, 0, 5, 0 degrees F. --There was no documented actions taken for temperatures that were outside the "adequate" temperature range. -There was ice build up around the door to the walk-in freezer. -The metal lining of the walk-in freezer door was separated and had exposed cracked foam. -There was frost on the cooling unit in the walk-in freezer and ice build-up on the pipes on the back of the unit. *The "3 Door Fridge Unit" had: -Two temperature gauges were being documented daily on the provider's form 403. -The temperature gauges were identified as "GUAGE A" and "GUAGE2". -Between November 1st through the 12th "GUAGE A" was documented as reading 36-41 degrees Fahrenheit. -During the same time frame "GUAGE2" was documented as 38-45 degrees F. -There were four days with greater than the 2-degree variance from 40 degrees. --There was no documentation of actions taken for temperatures that were outside the "adequate" temperature range. -A container of diced ham in the three-door refrigerator dated 10/24. -There was uncooked corn beef hash stored above the potatoes and wine. *Another stand-up freeezer had: -Two baked pies with pieces removed that were dated 9/22 and 8/18.	F 812	Audits will be conducted weekly times 4 weeks and monthly times 2 months to ensure all refrigerator and freezer temperatures are logged and that the temps are within appropriate ranges. The audits will also ensure that proper interventions were put into place if the temperatures were out of safe ranges. Audits will also include checking for appropriate food storage procedures of all refrigerated and frozen foods. The administrator/designee will be responsible for conducting the audits. The administrator will be responsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on 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. 2. The facility policies, "Freezer", "Refrigerator - Reach in", "Food Storage", and "Refrigerator Storage Chart", were reviewed by the administrator, registered dietitian, and dietary manager on 12/3/2024, and were deemed appropriate. Education was provided to all Continued on next page.....	

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F 812	Continued From page 26 --The pies were covered loosely with plastic wrap. *The plastic liners in the flour and sugar containers were ripped. 2. Observation on 11/14/24 at 9:22 a.m. of the kitchen revealed: *The office freezer had: -Chicken nuggets that were not dated. -One thermometer that had a solid red line that extended to 34 degrees Fahrenheit with a broken red line extending from 34 degrees to 52 degrees Fahrenheit. *The walk-in refrigerator had dust on the front of the cooling unit and on the walls and ceiling. *The walk-in freezer had: -There were no documented actions taken for the temperatures that were outside the "adequate" temperature range. -Dates on the bags of cut up chicken ranged from 1/8 to 11/3. -There were multiple bags of undated cut-up chicken. -One bag of undated chicken pieces appeared freezer burned, and the bottom of the bag contained a frozen bloody liquid. -There was ¾ inch of frost build-up on the side of the walk-in cooler cooling unit that extended to 1/3 of the front portion of the unit. -The back of the walk-in cooler cooling unit had one to three inches of ice build-up on the back of the unit that extended onto the tubing behind the unit. *In the three-door refrigerator there was a container of frozen meat that extended above the sides of the container and was stored above wine and a box of pastries. 3. Interview on 11/14/24 at 9:22 a.m. with dietary manager T revealed:	F 812	dietary staff by the administrator and dietary manager on the policies mentioned above and to ensure that all refrigerated and frozen foods are labeled & stored properly, that thermometers are in good working order, & that the insides of refrigerators and freezers are cleaned properly per facility policy. The chicken mentioned in the 2567 was destroyed on 11/14/2024. The entire inside of the walk-in coolers were thoroughly cleaned on 12/2/2024 and have been included on routine cleaning schedules. All thermometers were checked over to ensure they were in good working condition on 11/15/2024 and replaced if necessary. Audits will be conducted weekly times 4 weeks and monthly times 2 months to ensure all refrigerated and frozen foods are labeled and stored according to facility policy, that the insides of refrigerators and freezers are cleaned routinely according to company policy, and that refrigerator/freezer therm-ometers are in good working order. The administrator/designee will be responsible for conducting the audits. The administrator will be resp-onsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of continued on next page.....	

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F 812	Continued From page 27 *She indicated that all freezer and refrigerator temperatures were documented daily and there needed to be two thermometers in the refrigerator and one in the freezer. *She indicated that if the two thermometers in the refrigerators did not match, she would check the temperature with another thermometer and discard the thermometer that did not read accurately. -She stated that this action was not documented anywhere. *When asked how she determined when food was discarded according to the dates on the packages, she stated she did not know the answer. *She stated she had discarded all the food that was thawed out in the walk-in freezer when the temperatures were out of range. *She stated she was told the walk-in freezer door was being replaced. *She indicated that on Friday (11/8/24) the cooling unit in the walk-in freezer was not working. -Maintenance director I removed the ice from the cooling unit and the cooling unit then began working. -Maintenance director I installed longer screws on the wall side exterior latch of the walk-in freezer so the door would latch. *She stated that the ice currently present on the cooling unit of the walk-in freezer was "better" than it was previously. *She agreed that the metal liner on the door of the walk-in freezer was separated with exposed cracked foam and light was visible around the door. *When shown the undated bag of chicken pieces that appeared freezer burned with frozen bloody liquid on the bottom of the bag, she indicated that	F 812	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 812	Continued From page 28 this bag appeared to have thawed and refrozen. -She did not throw out any of the turkey or chicken on that Friday because she felt they had not thawed. -She said she would dispose of that bag of chicken. -The bags of chicken should be dated. *She stated that maintenance oversaw the cleaning of the cooling unit in the walk-in refrigerator. *She indicated that when she defrosted meat in the cooler, and "raw meat" needed to be stored on the bottom shelf in a container. *If meat was precooked, she did not put it on the bottom of the refrigerator. *If meat needed to be defrosted more rapidly than able to in the refrigerator she would "run it under cool water." 4. Review of the provider's temperature logs revealed: *On 10/9/24 dietary manager T documented on the "Walkin Frig and Freezer" titled temperature log margin "Got rid of the stuff out of [the] freezer". -Below the above documentation was written "Freezer door wouldn't shut but got fixed on the 8th". *Daily documented freezer temperatures for "Walkin Frig and Freezer" reported in degrees Fahrenheit between October 1st and 11th, 2024 were 22, 20, 18, 20, 20, 20, 18, 20, 20, 22, 23. -There was a note in the margin that stated, "walk in door not shutting properly Got rid of all the food" *Logs of freezer defrosting was requested but not provided 5. Interview on 11/14/24 at 9:40 a.m. with dietary	F 812		

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F 812	Continued From page 29 aide P revealed that she was unfamiliar with the process of checking temperatures in the coolers because the cooks performed this task. 6. Interview on 11/14/24 at 9:45 a.m. with dietary aide V revealed: *If the two thermometers in the refrigerator did not match, she would double-check the gauge that was reading out of range. *If she determined that gauge was reading inaccurately, she would notify her supervisor to replace the inaccurate gauge. 7. Interview on 11/14/24 at 4:39 p.m. with administrator A regarding the kitchen revealed: *She was aware the walk-in refrigerator door had ice build-up around the door. *They had "thrown out food numerous times" after identifying the food had partially thawed out. -She was not aware the chicken and turkey had not been thrown away after having been partially thawed out. 8. Review of the provider's 8/31/18 Freezer policy revealed: *Freezer defrosting was to be completed monthly. *Freezers should remain frost free. 9. Review of the provider's 10/15/18 Freezer Storage Chart revealed: *Unopened frozen chicken nuggets were to be disposed of after 1-3 month *Unopened whole or cut up chicken was to be disposed of after 10 months. *Baked pies were to be stored unopened and be disposed of after 8 months. *Opened baked pies recommended storage was "not applicable".	F 812		

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F 812	Continued From page 30 10. Review of the provider's 3/9/20 Food Storage policy revealed: *Products were to be examined for signs of defrosting. *The "refreezing of defrosted food is not recommended because of increase in growth of-food bacteria and the deterioration in food quality". *"Thaw meat preferably by placing in deep pan and setting on the lowest shelf in refrigerator." *"Thawing food under cold running water is no longer recommended due to strict guidelines set forth by the 2013 Food Code. *"Alcoholic beverages must be stored in a separate locked area." 11. Review of the provider's 8/8/19 Record of Refrigeration Temperatures policy revealed: *"A daily temperature record is to be kept of refrigerated items. *"The freezer must be clean and food must be frozen solid with no indications of thawing and must be frost free. *"The refrigerator must be 41 degrees Fahrenheit or less (1-2-degree variance)" *"Note on temp forms the plan of action when temps are not acceptable." 12. Review of the provider's 12/28/20 Refrigerated Storage Chart policy revealed that opened ham should be discarded after one week.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880	1. The facility policy - "Sanitation", was reviewed by the administrator and register-ed dietitian on 12/3/2024, and deemed appropriate. 1.The ice machine mentioned in the 2567 was taken out of service the afternoon of 11/14/24. This machine is still out of service as the ice making mechanism of continued on next page.....	12-12-2024

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F 880	Continued From page 31 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 control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880	the machine has not been working for the past three 3 months. CMA U was incorrect when she stated to the surveyor that all three resident ice water passes were conducted out of that ice machine. This type of ice machine does not produce enough ice to accomodate the volume of ice water mugs needed for our number of residents. The ice machine and sink near the ice machine in dietary are used for all morning and afternoon ice passes. The ice machine located in the time clock room is used for the night time ice water passes. The kitchen sink in Rushmore dining room is used to fill the water into the mugs for the night time water passes. The product recommended by the manufacturer of two of our ice machines was ordered and recieved in the facility on 11/24/24. The ice machine listed in the 2567 (which is still out of service until the ice producing mechanism is repaired and the grid over the tray is replaced or repaired) and another machine located in Independence Dining room, which is the same model, were both sanitized on 12/5/24, per the manufacturer's guidelines by our maint-enance department. The weekly cleaning instructions for the ice machine per the manufacturer's guidelines has been included on a cleaning schedule for dietary staff to complete. The every 6 month cleaning/sanitizing procedure per the manufacturer's guide-lines has been included on the ice machine cleaning schedule for maintenance to complete. All dietary and maintenance staff were educated on 12/4/2024, by the admin-istrator to ensure these ice machines are cleaned per the manufacturer's guidelines when required. continued on next page.....	

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F 880	Continued From page 32 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, record review, policy review, and manufacturer's recommendations, the provider failed to ensure one of two observed ice machines were maintained in a clean and sanitary manner. Findings include: 1. Observation on 11/14/24 at 9:22 a.m. of an ice machine located in the therapy room revealed: *The water/ice spout had pink slime (a bacteria colony that can grow in ice machines) in it. *The water tray had metal bars over the top of it that were rusted. *There was a white, flaky, residue, that covered the underside of the machine where the spout extended from.	F 880	Audits will be conducted by the administrator/designee weekly times 4 weeks and monthly for 2 months to ensure the ice machines are being cleaned according to manufacturer's guidelines. The administrator will be responsible for overalll compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of the correction plan, for recommendations to adjust the correction plan, reduce frequency of audits based on the audit findings. 2. The facility policy - "Transmission Based Precautions" was reviewed by the DON and administrator on 12/3/24 and was deemed appropriate. Resident's 274 and 424 were placed on contact precautions during the survey on 11/14/24. All residents on transmissin based precautions are at risk of not being placed on the appropriate type of precautions. All nurse managers and nurses were educated on 12/4/24, to continued on next page.....	

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F 880	Continued From page 33 Interview on 11/14/24 at 9:22 a.m. with certified medication aide (CMA) U regarding the ice machine located in the therapy room revealed that the ice machine was used three times daily for resident water passes. Interview on 11/14/24 at 1:42 p.m. with housekeeper K regarding the ice machine located in the therapy room revealed: *Each housekeeper is assigned a different area to keep clean. *He has cleaned the ice machine, by having wiped down the outside areas of it. *He said the housekeepers do not clean the internal parts of the ice machine. *He said supervisor would know more about the ice machine. Interview on 11/14/24 at 1:46 p.m. with housekeeper supervisor R regarding the ice machine located in the therapy room revealed: *Housekeepers wiped down the outsides of the ice machine. *She said housekeepers had tried to keep the ice machine clean. *She confirmed the bars on the tray were rusted, and did not know if they could be replaced. *She confirmed there was pink slime on spout of the machine. *She said the maintenance staff takes apart and does the internal cleaning of the ice machine. Interview on 11/14/24 at 1:49 p.m. with maintenance director I regarding the ice machine located in the therapy room revealed: *Confirmed there was pink slime on the spout of the ice machine. *Used a brush to clean it every six months.	F 880	ensure they understand the facility policy on the different types of precautions to ensure they place residents on the appropriate precaution type when it is warranted due to an infection they are diagnosed with. Audits will be conducted weekly times 4 weeks and monthly for 2 months to ensure that the appropriate precautions are in place for residents that have diseases that warrant them to be on precautions. The DON/designee will be responsible for conducting the audits. The DON will be responsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of the corrrection plan, reduce the frequency of the audits, or discontinue the audits based on audit findings. 3. The facility policy - "Transmission Based Precautions" - was revised on 12/2/24, to include appropriate procedures for infection prevention when administering medication for residents that are on transmission based precautions. All nurse managers and nursing staff were educated on 12/4/2024 on this newly revised policy to ensure that appropriate steps for infection prevention are taken when administering medications for all residents including residents on transmission based precautions. All residents on transmission based precautions, were reviewed to ensure that they are on the appropriate precaution type. All residents on transmission based precautions are at risk for nursing to miss a step in infection prevention during medication administration. continued on next page.....	

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F 880	Continued From page 34 *A chlorine spay product was used. *The product observed was CDS liquid chlorinator pool water disinfection. -He said he would pour that into a spray bottle and would add "a little" water to it. -He said he does not measure the amounts of the product or the water he would add to the spray bottle. Review of the provider's Ice Machine Log Semi-Annual Inspection revealed: *The 4/13/24 documentation included "cleaned/checked". *The 7/27/24 documentation included "checked cleaned as needed cleaned air filters". *The 10/22/24 documentation included "Cleaned all Ice machine/cleaned Ran through cleaning cycles/filters." Review of the provider's June 2019 Sanitization policy revealed: *"Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy." *"Damaged or broken equipment that cannot be repaired shall be discarded." Review of the manufacturer's instructions for installation, operation, and maintenance of the Manitowoc ice machine that was located in the therapy room revealed: *"Manitowoc Ice Machine Cleaner and Sanitizer are available in convenient 16 oz (473 ml) and 1 gal (3.78l) bottles. These are the only cleaner and sanitizer approved for use with Manitowoc products." *"Preventative Maintenance Cleaning Procedure Perform this procedure as required for your water conditions. Recommended monthly.	F 880	All residents with nasal sprays are also at risk for nursing to miss a step in infection prevention following a nasal spray administration by not wiping the tip of the nasal applicator following such administration. All residents with nasal sprays were reviewed with our pharmacy consultant to determine the frequency of cleaning the tips of the nasal spray applicators per the manufacturer's recommendations for each different type of nasal spray. Directions are now included within each nasal spray adminsitration order to include the frequency and type of cleaning for each nasal applicator tip per the manufacturer's recommendation. Audits will be conducted on resident 44's nasal spray administration and 4 other random resident nasal spray administration's weekly times 4 weeks and monthly times 2 months to ensure that the proper cleaning of the tips per the manufacturer's recommendations is conducted following the administration. The DON/designee will be responsible to conduct these audits. The DON will be responsible for overall compliance and will report audit findings at monthly QAPI meetings for 3 months for discussion on the effectiveness of the correction plan, reduce the frequency of the audits, or discontinue the audits based on the audit findings.	

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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 880	Continued From page 35 -Allows cleaning the ice machine without removing all of the ice from the bin -Removes mineral deposits from areas or surfaces that are in direct contact with water during the freeze cycle (reservoir, evaporator, auger, drain lines)." *"Cleaning/Sanitizing Procedure This procedure must be performed a minimum of once every six months. -All ice must be removed from the bin -The ice machine and bin must be disassembled cleaned and sanitized -The ice machine produces ice with the cleaner and sanitizer solutions -All ice produced during the cleaning and sanitizing procedures must be discarded." *"Ice machine sanitizer is used to remove algae or slime." *"Refer to the chart and add the correct amount of sanitizer and cool water for your model ice machine." *"Remove the top cover from the ice chute and pour the sanitizer/water solution into the evaporator. Add the entire amount of premixed solution". Interview on 11/14/24 at 4:39 p.m. with administrator A regarding the ice machine located in the therapy room revealed: *She was not aware the appropriate chemicals for cleaning and sanitizing the machine were not being used. *Her expectation was for the manufacturer's recommendations for cleaning and sanitizing to be followed. B. Based on observation, record review, interview, and policy review the provider failed to ensure two of two sampled residents (274 and	F 880		

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	435020	A. BUILDING _____ B. WING _____	C 11/14/2024

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AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

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F 880	Continued From page 36 424) had been placed on contact precautions due to having been diagnosed with a multi-drug resistant organism (MDRO) infection. Findings include: 1. Observation on 11/14/24 at 2:30 p.m. of resident 274's door revealed: *She had a sign that indicated to check in with the nurse before entering the color of the sign was pink indicating enhanced barrier precautions. *PPE (personal protective equipment worn to minimize exposure to a hazard, such as gowns, gloves, face shield and masks) was on the outside of the door. Review of resident 274's electronic medical record (EMR) revealed: *She had been admitted 11/4/24 with a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA) to her left ankle. *She had been receiving intravenous (IV) antibiotics through her peripherally inserted central catheter (PICC) and had been using a wound vacuum. *Resident 274's care plan indicated she had been on enhanced barrier precautions due to her wound and PICC line. Interview on 11/14/24 at 2:45 p.m. with clinical care coordinator registered (RN) C regarding resident 274's enhanced barrier precautions revealed: *She had known that resident 274 had a diagnosis of MRSA upon admission. *Agreed that resident 274 had not been on contact precautions for her MRSA infection in her wound. 2. Observation on 11/12/24 at 4:22 p.m. of	F 880		

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	435020	A. BUILDING _____ B. WING _____	C 11/14/2024

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

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F 880	Continued From page 37 resident 424 revealed: *There was PPE hanging in a supply caddy on her door. *She had a sign that indicated to check in with the nurse before entering the color of the sign was pink indicating enhanced barrier precautions Observation on 11/13/24 at 8:37 a.m. of resident 424 revealed: *She was being propelled in her wheelchair by an unknown staff member out of the dining room. *The same unknown staff member stopped in the hallway and assisted her to stand and ambulated with assistance of one staff and a front wheeled walker in the hallway. Interview on 11/13/24 at 10:03 a.m. with resident 424 revealed that she: *She was admitted to the facility about three weeks ago. *She had sores on her feet that she said resulted from her falling and laying on a garage floor for "about two to three days" before she was found. Review of resident 424's electronic medical record (EMR) revealed: *She was admitted on 10/25/24. * On 10/6/24 she was diagnosed with a positive Methicillin-resistant Staphylococcus aureus (MRSA) (a bacteria that is resistant to multiple antibiotics) in her right ankle wound. *She was taking Linezolid for the MRSA infection. Interview on 11/13/24 at 11:58 a.m. with licensed practical nurse (LPN) Y revealed: *She identified that resident 424 was on EBP by the color of the sign on her door. *She stated that resident 424 was on EBP due to her wounds.	F 880		

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	435020	A. BUILDING _____ B. WING _____	C 11/14/2024

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 880	Continued From page 38 Interview on 11/14/24 at 1:38 p.m. with clinical care coordinator, RN C and director of nursing (DON) B regarding resident 424 revealed: *She was on EBP due to her wounds. -She was recently diagnosed as being positive for MRSA in one of her wounds. --That was an indication to advance her precautions from EBP to contact precautions. *RN C agreed that resident 424 was not advanced from EBP to contact precautions. 3. Review of the provider's 2/20/24 MRSA policy revealed: * "Risk of transmission increases in the following situations and therefore, contact precautions and/or droplet precautions should be considered: Any site with active MRSA infection". * "Consideration could be to use Enhanced Barrier Precautions [EBP] when the resident no longer meets the definition for contact precautions." * "Resident may not leave the room while in precautions except for medically necessary reasons. When the resident leaves the room, precautions should be maintained to minimize the risk of transmission of pathogen to others and containment of environmental surfaces or equipment." C. Based on observation, interview, and policy review, the provider failed to ensure infection control and prevention practices were maintained by one of one licensed practical nurse (LPN) Q during medication administration for one of one sampled resident (44). Findings include: 1.Observation on 11/13/24 at 9:35 a.m. of LPN Q during resident 44's medication administration revealed:	F 880		

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	435020	A. BUILDING _____ B. WING _____	C 11/14/2024

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F 880	Continued From page 39 *Resident 44 was on precautions for COVID-19. *With personal protective equipment (PPE) (gown, gloves, shield, and N95 mask) on: -She picked up a medication cup off of the medication cart that contained resident 44's prepared medications. -She knocked on resident 44's door and went into her room. -She sat the cup of medications and a nasal spray, down on a bedside table. -She assisted the resident into a more upright position in bed. -She administered the nasal spray into the left nostril, recapped the nasal spray, and set it back down on the bedside table. -Once she finished administering the rest of the medications, she removed the full trash bag in the bathroom and replaced it with a new one. -She removed her shield, gown, and gloves and washed her hands with soap and water. -She picked up the nasal spray and trash bag and then left the room. *Outside of the room by the PPE cart she: -Placed the trash bag into another trash can. -Placed the nasal spray on the PPE cart, discarded her mask into the trash can, and used hand sanitizer to disinfect her hands. -Picked up the nasal spray, opened the medication cart, and put the nasal spray back into the nasal spray manufacturer's original box. 2. Interview on 11/13/24 at 4:26 p.m. with LPN Q revealed: *She knew she did not wipe off the nasal applicator after administering the nasal spray to resident 44. *She did not think she was allowed to wipe down something that went into a nasal cavity.	F 880		

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	435020	A. BUILDING _____ B. WING _____	C 11/14/2024

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

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F 880	Continued From page 40 3. Interview on 11/14/24 at 10:30 a.m. with registered nurse (RN) infection preventionist E revealed: *Nurses were to wipe off the nasal spray applicator in precaution rooms with an alcohol wipe. *Nurses were to clean the bottle outside of the room and then put it back in the medication cart. 4. Interview on 11/14/24 at 11:25 a.m. with staff development coordinator D revealed: *She educated staff on PPE, handwashing, different isolation precautions, infection control, and types of transmission every year. *She stated for nasal sprays, staff were supposed to wipe the tip off after every application with an alcohol wipe. *She did not believe there was any education regarding wiping off nasal spray bottles once out of precaution rooms. 5. Interview on 11/14/24 at 11:35 a.m. with director of nursing DON B revealed: *Staff had not received education "recently" regarding infection control practices. *They had not provided staff education for administering nasal spray in precaution rooms. *Her expectation was for staff to place a barrier down for nasal sprays and wipe the nasal applicator after each use. The provider's Nasal Spray Administration policy dated 11/21/18 and Infection Prevention Program policy revised 2/20/24 did not address infection control practices following nasal spray administration in precaution rooms.	F 880		

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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 on 11/13/24. Avantara Huron was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie L. Solem	Administrator	12/06/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/13/2024**

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 was conducted on 11/13/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Huron was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the	K 353	Building Sprinkler, Inc., will be at the facility on 12/10/2024 to replace and repair the main shut off valve listed as deficient in the 2567. The Sprinkler system is already included in the TELS system to be checked monthly by the maint-enance staff. Our Maintenance Director had requested Building Sprinkler, Inc., numerous times over the past year to repair the valve leak on the system and he was the person that asked the technician to write it on the report so that it would alert Building Sprinkler to get it repaired. Education was provided to the Maintenance Director to involve the administrator when these types of items don't get addressed. Weekly audits will be conducted by the maintenance director/designee for 4 weeks and then monthly for continued on next page.....	12/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie L. Solem	Administrator	12/06/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/13/2024**

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 353	Continued From page 1 provider failed to continuously maintain automatic sprinklers in reliable operating condition (annual inspection had revealed significant system degradation). Findings include: 1. Document review on 11/13/24 at 10:00 a.m. revealed the annual inspection report for the inspection conducted on 10/3/24 noted the main shutoff valve for the fire sprinkler system was severely corroded to the point that valve operation was difficult. The OS&Y valve, used to assure sprinkler system water does not cross contaminate drinking water supplies was leaking significantly. The sprinkler technician was able to stop the leak with assertive turns. Stopping the leak in this manner may not be a permanent repair. During the exit interview on 11/13/24 at 11:45 a.m. the administrator and the maintenance supervisor revealed they had not seen the comment on the annual report. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests for the automatic sprinkler system.	K 353	2 months to ensure the leaking has stopped once the valve has been repaired. The maintenance director is responsible for overall compliance and will report audit findings at monthly QAPI meetings for discussion on the effectiveness of the correction plan, for recommendations to adjust the correction plan, reduce the frequency of the audits, or discontinue the audits based on the audit findings.	

South Dakota Department of Health

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	10633	A. BUILDING: _____ B. WING _____	11/14/2024

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 11/12/24 through 11/14/24. Avantara Huron was found not in compliance with the following requirements: S295.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the	S 296	Three cooks are registered to take the next available ServSafe Course through the South Dakota Retailer's Association on 2-5-2025, in Sioux Falls, SD. In review of S296 the facility discovered that we do have one other full-time cook who was employed at the time of survey, does have an active ServSafe certification with an effective date of 5/26/2021, which expired on 5/26/2026, which had not been uploaded in the HR system. The facility Human Resources Director will track the expiration dates of all staff who are ServSafe certified to ensure that we always have at least two dietary staff - one of which being the Dietary Manager, is Serv-Safe certified at all times. The Dietary Manager will be responsible for overall compliance and the Dietary Manager/designee will conduct monthly audits for 3 months following the additional three staff completing their ServSafe certification process to ensure we have at least two staff members ServSafe certified at all times. The Dietary Manager will report audit findings at monthly QAPI meetings for 3 months to ensure compliance.	2/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem | TITLE: Administrator | (X6) DATE: 12/06/2024

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10633	A. BUILDING: _____ B. WING _____	11/14/2024

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S 296	Continued From page 1 residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview the provider failed to ensure at least one cook was ServSafe certified as required. Findings include: 1.Interview on 11/14/24 at 9:22 a.m. with dietary manager (DM) T revealed: *She was ServSafe certified. *There were no other employees ServSafe certified. *She knew one other person besides herself should have been certified. Interview on 11/14/24 at 5:43 p.m. with administrator A regarding ServSafe certification revealed: *DM T was certified. *There were no other employees certified. *She was aware one other person besides DM T should have been certified.	S 296		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 11/12/24 through 11/14/24. Avantara Huron was found in compliance.	S 000		