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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING B. WING	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET , GROTON, South Dakota, 57445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/9/25 through 12/11/25. Avantara Groton was found in not in compliance with the following requirements: F578, F641, F655, F658, F700, F761, F803, F812, and F880.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an	F0578		0125.26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda	LNHA	0114.26

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F0578 SS = D	Continued from page 1 advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for three of three sampled residents (1, 23, and 37) was currently and accurately documented in the residents' electronic medical records. Findings include: 1. Interview on 12/10/25 at 2:54 p.m. with resident 37 revealed: *The staff had spoken with him when he was admitted about his wishes if his heart were to stop (advanced directives or code status). *He told them he wanted a do not resuscitate (DNR) (no cardiopulmonary resuscitation [CPR] or other heroic measures would be started if his heart or breathing stopped) code status. Review of resident 37's electronic medical record (EMR) revealed: *He was admitted on 11/14/25. *His Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. *The advanced directives area in the EMR banner (a resident information area on the EMR screen) was blank. *His physician's orders did not include his advanced directives wishes. *His 11/14/25 admission progress note did not indicate what his resuscitation wishes were. *His EMR documentation did not include his DNR wishes. *His 12/10/25 care plan indicated on 11/18/25 his	F0578	1. Resident 37-Immediate corrective action-resident EMR banner was updated on 12.10.25. Physician's order stating advance directive was requested and received on 12.11.25. Resident 1-Immediate corrective action , EMR Banner updated. Resident 23-No immediate corrective action as advanced directive document was received and uploaded on date of admission 03.1.24. 2. All residents have the potential to be at risk. A full house audit was conducted on 12.17.25 by Regional Nurse Consultant to ensure every resident has a signed advanced directive, that it matches what is on the EMR Banner and dot color on resident's door. The DON will educate nursing team and SSD on Advanced Directives Policy no later than 01.25.26. 3. The DON or designee will review all new admits to ensure advanced directives are noted in admission notes, EMR Banner matches note and dot color is correct on door. The audit will be weekly for 4 weeks then monthly for 2 months. Results will be reviewed and discussed by the Admin or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	0125.26

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F0578 SS = D	Continued from page 2 wishes were to be a DNR. *His EMR included his signed advanced directives to initiate CPR, from his previous 8/16/25 admission to the facility. 2. Review of resident 1' EMR revealed: *He was admitted on 10/17/25. *His 10/17/25 admission progress notes indicated he was a "full code [to start CPR if his heart or respirations stop] at this time per wife" *On 10/18/25 resident 1's representative signed a form that indicated a DNR code status. -The physician signed that form on 10/21/25. *There was a 10/22/25 "DNR" physician's order. 3. Interview on 12/11/25 at 2:17 p.m. with licensed practical nurse (LPN) I revealed: *A resident's code status could be found under the miscellaneous tab in the resident's EMR, and on the EMR banner. Residents with full code statuses were to have a red dot near their door. *Residents usually were admitted from the hospital with a physician's order that indicated their code status. *Residents are to be asked upon admission what their code status wishes were. *The resident's code status would be updated on the EMR banner by the nurses or medical records person once the order was received from the physician. *If the code status was not documented in the physician orders or on the EMR banner, it could be in the admission progress notes. 4. Interview on 12/11/25 at 4:27 p.m. with regional nurse consultant D revealed: *The resident's advanced directive was to be entered onto the resident's EMR banner and the physician's orders immediately upon admission to the facility. *She explained she would not wait for a physician's signature on the resident's advanced directive before entering them into the resident's EMR, because the advanced directives were to be based on a resident's	F0578		0125.26

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F0578 SS = D	Continued from page 3 wishes not the formality of a physician signature. *She agreed that the time lapse between the resident representative's designating resident 1 as a DNR code status and the physician's signature had the potential for resident 1's advanced directive wishes to not have been followed. *She verified that resident 37 did not have his current advanced directives in his EMR or on his EMR banner. 5. Review of resident 23's EMR revealed: *She was admitted to the facility on 3/1/24 from the hospital. *Her hospital discharge paperwork included "resuscitation status: full resuscitation" [full code]. *Her EMR banner stated, "Advance Directives: DNR [do not resuscitate]". *There was no signed document in her EMR that stated her code status wishes. *Social services director/interim administrator C completed her admission assessments on 3/4/24. The note stated "DNR code status remains." *Resident 23 confirmed wishes to be DNR status on 12/10/25. 6. Interview on 12/10/25 at 11:10 a.m. with LPN [licensed practical nurse) H revealed: *The facility does not use paper charts. All documents are uploaded to the resident's electronic chart. 7. Interview on 12/9/25 at 9:29 a.m. with certified nursing assistant (CNA) T revealed: *A resident had a full code status if they had a red dot next to their name on the sign by the door to their room. *The staff could also look at the banner in the resident's EMR to quickly see their code status. 8. Interview on 12/10/25 at 2:55 p.m. with LPN I revealed:	F0578		0125.26

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F0578 SS = D	Continued from page 4 *The nurses were to ask the resident their code status wishes when the resident admitted to the facility. *The signed form was to be sent to medical records staff to scan into the resident's EMR. *The EMR banner was to be updated with the resident's code status by the nurses. *The nurses were to document the resident's choice is for code status in the admission progress note. 9. Interview on 12/11/25 at 3:13 p.m. with registered nurse (RN)/ minimum data set (MDS) coordinator E revealed: *When a resident admitted to the facility, social services director/interim administrator C was responsible for speaking with the resident about their code status wishes, putting their choice in the resident's care plan, and sending the document to the provider to sign. *Social services director/interim administrator C was not available for interview at the time of the survey. 10. Interview on 12/11/25 at 7:56 a.m. with regional nurse consultant D revealed that she could not find any signed document in resident 23's EMR regarding her code status. 11. Further interview on 12/11/25 at 4:38 p.m. with regional nurse consultant D revealed: *She expected the resident's code status to be updated on admission to the facility. *She expected the EMR code status banner and the physician's order to be accurate. *She agreed that the resident's wishes should be updated regardless of having a physician's signature on the document. *She agreed that there was a risk for not following the resident's wishes if the code status was not updated immediately. 12. Review of the provider's 5/14/25 Advanced	F0578		0125.26

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F0578 SS = D	Continued from page 5 Directives policy revealed that: "Each resident was to choose their advance directives on admission. "An advance directive form shall be completed with the resident and/or legal representative to verify treatment options as well as code status." "If the resident is unable or chooses not to initiate any type of advance directive, it is the policy of this facility for the resident to be a full code and to receive appropriate life sustaining treatment interventions such as CPR." "The resident's choice of code status will be added to the physician order sheet. "The resident's advance directive and treatment options/refusals will be documented in the medical record, as well as, care planned during the admission process."	F0578		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F0641		01.25.26

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F0641 SS = E	Continued from page 6 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment: or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure five of five sampled residents' (4, 7, 8, 19, and 37) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas of weight loss, Pre-Admission Screening and Resident Review (PASRR), insulin administration, and pneumococcal (pneumonia) vaccination status. Findings include: 1. Interview on 12/9/25 at 4:10 p.m. with resident 8 revealed she had a history of trauma and was receiving counseling services. Review of resident 8's electronic medical record (EMR) revealed: *She was admitted on 4/12/22. *Her diagnoses included delusional disorder (a mental illness where a person holds strong, false beliefs despite evidence to the contrary), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder (PTSD) (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), and bipolar disorder (mental condition causing extreme shifts in mood, energy, and activity levels). *She had a level I (1) PASRR completed on 2/14/25 due to a change in her medications. -The Level I PASRR stated, "Your Level I screen was	F0641		0125.26

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F0641 SS = E	Continued from page 7 submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation." -"The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?'" *There was no Level II PASRR in resident 8's EMR. *Item A1500 in section A of her 9/19/25 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" -Item A1500 in section A was coded "No" on resident 8's 4/28/22, 9/9/22, 6/20/23, 10/4/23, and 9/30/24 comprehensive MDS assessments. 2. Review of resident 4's EMR revealed: *He was admitted on 10/11/21. *He had a diagnosis of diabetes (a condition involving disruptions in how the body regulates blood sugar). *His blood sugar levels were to be monitored every Monday, Wednesday, and Friday by the nursing staff. *A 11/23/24 physician's order for "Trulicity [injectable medication for treating diabetes] Subcutaneous [under the skin in the fatty tissue layer] Solution Pen-Injector 0.75 MG [milligrams]/0.5ML [milliliter] (Dulaglutide) Inject 3 mg subcutaneously one time a day every Sat [Saturday]." *Item N0350A of section N of her 9/9/25 quarterly MDS assessment was coded as she had received insulin injections one times during the seven-day look-back period (the time period over which the resident's condition or status is captured by the MDS assessment) of that MDS. -Trulicity's medication classification was a glucagon-like peptide-1 (GLP-1) agonists, not an insulin.	F0641	1. Resident 8-No immediate corrective action could be completed for MDS dates 4/28/22, 9/9/22, 6/20/23, as they are out of the 2 year window for change per CMS-MDS' for dates 10/4/23 and 9/30/24 were updated 01.05.26 to reflect a "Yes" for section A1500. Resident 4 the quarterly MDS on 9/9/25 item N0350A was corrected on 12/31/25 to reflect insulin has not been given. Resident 37-Immediate intervention-resident given vaccine on 12.11.25. Resident consented to the vaccine on 11.14.25 page 20 of admission paperwork. The vaccine was ordered 12.09.25 from pharmacy, but not administered.. MDS modified 12.31.25. Residents 19 & 7. No immediate corrective action could be completed. Dietary Manager corrected the MDS' on 01.07.26. Resident 8 Level II-No Corrective Action as her PASRR was in the EMR uploaded on 04.12.22. 2. All residents have the potential to be at risk. The DON will in-service the MDS Coordinator and Dietary Manager no later than 1/25/26 regarding the importance of accurate assessment and coding for MDS assessments to ensure future compliance with this deficiency. 3. The Director of Nursing (DON) or designee will complete 4 MDS reviews per week to verify the accuracy of MDS sections A1500, O0300A & N0350A. The audit will be weekly for 4 weeks then monthly for 2 months.Results will be reviewed and discussed by the Director of Nursing (DON) or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0641 SS = E	Continued from page 8 3. Review of resident 37's EMR revealed: *He was admitted on 11/14/25. *He had received a PCV13 (Pneumococcal Conjugate Vaccine) on 10/6/2020. *There was no documentation that he had received other pneumococcal vaccines in his EMR. *There was no documentation that resident 37 had been offered or refused his next dose of a pneumococcal vaccine. *Item O0300A of section O of his 12/2/25 comprehensive MDS assessment was coded as he was up to date on his pneumococcal vaccinations. 4. Review of the Center for Disease Control and Prevention's (CDC) Pneumococcal Vaccine Timing for Adults revealed if someone over the age of 50 years of age had received a PCV13 vaccine, it was recommended that a PCV20 or a PCV21 vaccination be administered after one year of having received the PCV13 for their pneumococcal vaccinations to be considered up to date. 5. Review of the Centers for Medicare and Medicaid Services' October 2023 Version 1.18.1 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual regarding insulin coding in section N revealed: "'Review the resident's medication administration records for the 7-day look-back period.' "'Determine if the resident received insulin injections during the look-back period." "'Enter in item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received." 6. Interview on 12/10/25 at 3:35 p.m. with registered nurse (RN)/MDS coordinator E revealed: *She was RAC-CT (Resident Assessment Coordinator-Certified) credentialed, which meant she completed courses regarding accurate coding of MDS 3.0 assessment and care planning. *She was responsible for ensuring all the residents' MDS assessments were completed accurately.	F0641		0125.26

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F0641 SS = E	Continued from page 9 *After reviewing resident 8's level I PASRR RN/MDS coordinator E verified resident 8 had a level II PASRR. -After reviewing resident 8's MDS assessments she verified resident 8's PASRR level II was coded inaccurately on the MDS. -She thought she may have clicked on "prior" to use the prior MDS data instead of reviewing the resident's EMR for changes. *After review of resident 4's medication orders in his EMR, RN/MDS coordinator E verified he was not on insulin. -She verified his 9/9/25 MDS assessment was coded inaccurately. *RN/MDS coordinator E stated that the residents' immunization information in the MDS auto populates from the resident's EMR system (PCC), and she did not enter the information. *After review of resident 37's MDS assessment she stated there was a triangle located beside the "yes" to the question regarding whether the resident was up to date on his pneumococcal vaccine. -The triangle indicated she had manually entered the response to the question. *She did not recall why she manually entered that response. *She verified resident 37's 12/2/25 MDS assessment was coded inaccurately. 7. Interview on 12/11/25 at 4:33 p.m. with regional nurse consultant (RNC) D revealed: *It was her expectation that the MDS assessments were coded accurately. *She verified resident 8's MDS assessment related to her PASRR was not coded correctly, resident 4 was not on insulin, and resident 37's pneumococcal immunizations were not up to date. 8. Review of resident 19's EMR revealed: *Her admission date was 5/26/23. *Her 9/15/25 nurse progress weight change note included a weight warning that her weight was 93.4 pounds (lbs),	F0641		0125.26

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F0641 SS = E	Continued from page 10 and was a 5.9 percent (%) increase in one month. Her 11/17/25 MDS indicated she had a significant weight loss of 5% (percent) in 30 days or 10% in 180 days. *Her weight record documentation indicated that: -On 11/17/25 she weighed 93.2 lbs., and on 10/17/25 she weighed 90.2 lbs., a weight gain of 3 lbs., this was 3.3% in one month. -On 8/15/25 she weighed 90.8 lbs., a weight gain of 2.4 lbs., a 2.65% on 11/17/25. -On 5/12/25 she weighed 95.6 lbs., a weight loss of 2.4 lbs., a 2.51% on 11/17/25. -The resident did not have a documented significant weight loss of 5% (percent) in 30 days or 10% in 180 days. 9. Review of resident 7's EMR revealed: *Her admission date was 6/6/25. *Review of her 9/12/25 MDS indicated she had a significant weight loss. *Her weight record documentation indicated that: -On 8/11/25 she weighed 97.0 lbs., on 9/9/25 she weighed 102.4 lbs., a weight gain of 5.4 lbs. in one month -On 6/6/25 she weighed 98 lbs., and on 9/9/25 she weighed 102.4 lbs., a weight gain of 4.4 lbs. in 3 months. -The resident did not have a documented significant weight loss of 5% (percent) in 30 days or 10% in 180 days. 10. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed section K Swallowing/Nutritional Status, page 4, definition for weight loss included: "DEFINITIONS 5% WEIGHT LOSS IN 30 DAYS Start with the resident's weight closest to 30 days ago (from the ARD) and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost weight." 11. Interview on 12/10/25 at 3:35 p.m. with RN/MDS	F0641		0125.26

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F0641 SS = E	Continued from page 11 coordinator E revealed: *Certified dietary manager (CDM) F was responsible for completing section K of the residents' MDS assessments. *She expected section K of the MDSs to be completed accurately. 12. Interview and record review on 12/10/25 at 4:01 p.m. with CDM F revealed: *She completed section K of the residents' MDS assessments. *She had "limited training" on how to complete the MDS. *She was aware there was an RAI manual but was not aware that there were instructions on how to complete section K of the MDS in that manual. *After review of resident 19's EMR and 11/17/25 MDS, CDM F confirmed she miscoded resident 19's weight as a significant weight loss on the MDS, and it should have been coded as a weight gain. -She indicated she used resident 19's weight report information and did not use 30 days from the ARD of 11/17/25 to calculate resident 19's weight gain or loss. *After review of resident 7's EMR and 9/12/25 MDS, she stated she marked the resident's "weight loss" in error on the MDS, and resident 7 had a weight gain. She was not sure why she coded that error. She confirmed 30 days from that MDS's ARD of 9/12/25 would have been 8/11/25, and resident 7 had weighed 97 lbs.	F0641		
F0655 SS = F	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 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.	F0655		01.25.26

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F0655 SS = F	Continued from page 12 (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 observation, interview, record review, and policy review, the provider failed to develop and implement a resident-centered baseline care plan within 48 hours of admission for four of five sampled residents (1, 3, 20, and 37) who were recently admitted.	F0655		01.25.26

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F0655 SS = F	Continued from page 13 Findings include: 1. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted on 3/28/25. *His 11/19/25 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. *A 3/31/25 progress note stated, "A copy of his admission summary note was provided to [the] resident. Baseline care plan was reviewed with [the] resident. Resident agrees and understands the baseline care plan." -The baseline care plan was reviewed with resident 3 three days after his admission to the facility. Review of resident 3's baseline care plan revealed focus areas of: *The new admission initial/interim care plan was initiated on 3/31/25. *Advanced directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) status initiated on 3/31/25 identified the resident wished to be a full code. *Discharge potential and discharge planning initiated on 3/31/25 identified resident 3's discharge goal to return home after completion of therapy. *"[Resident 3] require/s Enhanced Barrier Precautions [glove and gown use when providing contact care] related to: indwelling foley [urinary catheter]" was initiated on 4/1/25. *"[Resident 3] requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)" was initiated on 4/1/25. -Interventions within the resident ADL focus were, *Assist resident with shower/bathing per schedule up to 2x/wk [two times per week]. [Resident 3] is able to voice preference of shower or tub bath" initiated on 5/1/25. - *Assist with application of appliances if needed (hearing aid, eyeglasses, dentures)", "Encourage	F0655	1.No immediate corrective action could be completed for residents 3,20 & 37--Baseline Care Plans for residents cannot be updated once they have been completed.. On 01.05.26 the IDT team revised the Baseline Care Plan process to ensure more detailed information is included in the baseline care plan and it is delivered to the resident within the required 48 hour timeline. Upon admission to the facility: 1.The nurse will complete the admission assessment in the care plan. 2. MDS coordinator will personalize the baseline care plan to add more detailed information about the resident 3. Additional departments (dietary/activities) will add more detailed information in their Sections 4. Nursing will scan the UDA and baseline care plan in one document and upload to PCC.4. SSD or designee will review, and offer a copy of the baseline care plan with the resident, or resident representative, within the required 48 hour timeline and put a progress note in PCC noting delivery to resident, or resident representative. 2.All newly admitted residents to the facility have the potential to be at risk. The Admin will in-service all nursing staff, MDS Coordinator and Social Services Director on the baseline care plan policy and timeline for delivering once a resident admits to the facility no later than 01.25.26. 3.The Director of Nursing (DON) or designee will review all new admissions each week to ensure it is delivered to the new admission within the 48 hour timeline and a progress note is entered stating it was delivered. The audit will be weekly for 4 weeks then monthly for 2 months. Results will be reviewed and discussed by the Director of Nursing (DON) or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0655 SS = F	Continued from page 14 participation in ADL's", "Keep call lights within reach when in bedroom or bathroom", initiated on 3/28/25. -"Provide DME [durable medical equipment] -wheelchair and walker" initiated on 4/1/25. *"[Resident 3] has an ADL Self Care Performance Deficit and Impaired Mobility" initiated on 4/8/25. -Interventions within the focus areas were, "BED MOBILITY -total assist of 1", "TRANSFER: partial/moderate", "WALKING: partial/moderate- very short distances occasionally", "DRESSING: partial/moderate for upper body dressing. Total assist for lower body dressing/footwear", "TOILET USE: total assist of 1", "PERSONAL HYGIENE/ORAL CARE: partial/moderate assist of 1". -All the interventions for resident 3's ADL self-care performance deficit and impaired mobility which identified the assistance required to safely care for resident 3 were initiated on 4/8/25, 11 days after he was admitted. 2. Interview on 12/9/25 at 2:40 p.m. with resident 37 revealed he did not recall if a staff member talked to him about his plan of care on his admission. Review of resident 37's EMR revealed: *He was admitted on 11/14/25. *His 12/2/25 BIMS assessment score was 14, which indicated his cognition was intact. *He did not have a progress note in his EMR that indicated his baseline care plan had been reviewed with him or a resident representative. Review of resident 37's baseline care plan revealed focus areas of: *The new admission initial/interim care plan was initiated on 11/14/25. *Advanced directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) status identified resident wish to be a full DNR that was initiated on 11/18/25. *Discharge potential and discharge planning was initiated on 11/18/25 that identified resident 37's discharge goal to return home after the completion of therapy.	F0655		01.25.26

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F0655 SS = F	Continued from page 15 **"[Resident 37] require/s Enhanced Barrier Precautions related to: straight caths [catheterizations] TID [three times a day] & [and] PRN [as needed]" was initiated on 11/19/25. **"[Resident 37] requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)" was initiated on 11/14/25. -Interventions within the resident's ADL focus that were initiated on 11/14/25: -"Assist [resident 37] with shower/bathing per schedule up to 2x/wk [two times per week]. [Resident 37] will voice preference of shower or tub bath". -"Assist with application of appliances if needed". -"Encourage participation in ADL's". -"Keep call lights within reach when in bedroom or bathroom". -"Provide DME -wheelchair and walker". -"Skilled Rehabilitation Therapy evaluation and treatment as indicated" initiated on 11/14/25. **"[Resident 37] has an ADL Self Care Performance Deficit and Impaired Mobility" was initiated on 11/25/25. -Interventions within the focus areas were, "BED MOBILITY -supervision/touching assistance", "TRANSFER: supervision/touching assistance", "WALKING: supervision/touching assistance with FWW", "DRESSING: Partial/moderate assist for upper body dressing. Total assist with lower body dressing/footwear", "TOILET USE: partial/moderate assist", "PERSONAL HYGIENE/ORAL CARE: partial/moderate assist". -All the interventions for resident 37's ADL self-care performance deficit and impaired mobility which identified the assistance required to safely care for resident 1 were initiated on 11/25/25, 11 days after he was admitted. *New admission care plan for the resident's preferred activities was initiated on 11/17/25. *Risk for fall was initiated on 11/19/25.	F0655		01.25.26

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F0655 SS = F	Continued from page 16 3. Interview on 12/9/25 at 4:00 p.m. with resident 1 revealed he: *Did not have any teeth but stated he was able to eat soft foods at home. *Had trouble chewing some foods since his admission to the facility because they were tough. *Would like to be involved in his discharge planning because he did not feel he was kept up to date on his goals and discharge information. Review of resident 1's EMR revealed: *He was admitted on 10/17/25. *His 10/25/25 BIMS assessment score was 13, which indicated his cognition was intact. *His 10/17/25 admission summary note stated, "He is WBAT [weight baring as tolerated] and wears O2 [oxygen] at 2 L/min [liters per minute] via nasal cannula...No dentures or hearing aides [aids]. No teeth. Fax sent to get orders for mech [mechanical] soft due to no teeth or dentures." *A 10/20/25 progress note stated, "Presented baseline care plan to resident. Educated on what a care plan is and why it is used. No other questions at this time." -The baseline care plan was reviewed with resident 1 three days after his admission to the facility. Review of resident 1's baseline care plan revealed focus areas of: *The new admission initial/interim care plan was initiated on 10/20/25. *Advanced directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) status was initiated on 10/20/25 that identified the resident's wish to be a DNR (do not resuscitate) code status. *Discharge potential and discharge planning identified resident 1's discharge goal to "***" on 10/20/25. **[Resident 1] requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting)" initiated on 10/17/25.	F0655		01.25.26

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F0655 SS = F	Continued from page 17 -Interventions within the resident ADL focus that were initiated on 10/17/25 were: -"Assist resident with shower/bathing per schedule up to 2x/wk [two times per week]. [Resident 1] is able to voice preference of shower or tub bath". -"Encourage participation in ADL's". -"Keep call lights within reach when in bedroom or bathroom". -"Provide DME [durable medical equipment] -wheelchair and walker". -"Skilled Rehabilitation Therapy evaluation and treatment as indicated" initiated on 10/17/25. "[Resident 1] has an ADL Self Care Performance Deficit and Impaired Mobility" initiated on 4/8/25. -Interventions within the focus areas were, "BED MOBILITY -partial/moderate assist", "TRANSFER: partial/moderate assist", "WALKING: supervision/touching assistance with FWW [front wheeled walker]", "DRESSING: substantial/maximal assist for upper body dressing. Total assist with lower body dressing/footwear", "TOILET USE: substantial/maximal assist", "PERSONAL HYGIENE/ORAL CARE: partial/moderate assist". -All the interventions for resident 1's ADL self-care performance deficit and impaired mobility which identified the assistance required to safely care for resident 1 were initiated on 10/30/25, 13 days after he was admitted. **New admission care plan for the resident's preferred activities was initiated on 10/27/25. *Alteration in nutritional status interventions initiated on 10/17/25 were "Monitor for signs and symptoms of dehydration and weight loss", Obtain weight as ordered", Offer extra fluids if not contreindicated", "Provide assistance with meals if indicated", "Provide diet and supplements as ordered", and "Provide good oral hygiene". -The alteration in nutritional status interventions did not identify that resident 1 did not have teeth and an altered diet order had been requested. 4. Review of resident 20's EMR revealed:	F0655		01.25.26

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F0655 SS = F	Continued from page 18 *She was admitted to the facility on 11/2/25. *She did not have a documented intervention on her care plan until 11/14/25. *Her interventions for activities of daily living (ADL's) in her care plan included: -Assist with application of appliance if needed -Encourage participation in ADL's -Provide durable medical equipment [DME] if needed -Transfer: partial/moderate assist 5. Interview on 12/11/25 at 2:17 p.m. with certified nursing assistant (CNA) P revealed she: *Referred to a paper care plan for new admissions or if she did not know what cares a resident required. *Was also able to access a resident's care plan in the computer in the Kardex (a report of the resident's care needs and interventions). 6. Interview on 12/11/25 at 2:37 p.m. with licensed practical nurse (LPN) I revealed: *The paper care plan referred to by CNA P were printed from each resident's Kardex. *The information on the Kardex was based off each resident's care plan. *The nurse completed the baseline care plan during the admission process on the day the resident was admitted by selecting pre-scripted options on the admission assessment. *The boxes that the nurse checked on admission would then generate the baseline care plan. *Within the focus areas such as nutrition and activities of daily living (ADL) the interventions auto-populated to be the same for every resident. *LPN I verified that resident 1's discharge goal on his baseline care plan was ***** and did not identify what resident 1's discharge goal was. 7. Interview on 12/11/25 at 3:13 p.m. with registered nurse [RN]/minimum data set [MDS] coordinator E revealed:	F0655		01.25.26

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F0655 SS = F	Continued from page 19 *When a new resident arrives to the facility, the nurses fill out a UDA form [UDA or user-defined assessment, a series of questions related to the resident's care with options to choose from that apply to the resident]. -The assessment form has the same choices for every resident. *After the form is filled out by the nurse, she adds the resident's name and any information that those nurses "may have missed". *Social services director (SSD)/interim administrator C fills in the rest of the admission form. *She stated that to her knowledge the activities department and dietary department do not document in the baseline care plan. *The assessment selections generate and create the care plan in the resident's electronic medical record [EMR]. *She would expect that each baseline care plan is resident-centered. *She agreed that the certified nursing assistants [CNAs] would not know how to care for a newly admitted resident if the care plan did not specify the type of transfer assistance the resident requires. *She expected base line care plans needed to be completed within 48 hours of admission. *SSD/interim administrator C would review the baseline care plan and provide a copy to the resident or resident representative within 72 hours of admission. *SSD/interim administrator C would document in a progress note in each resident's EMR that the baseline care plan was reviewed with the resident or the resident representative and a copy had been offered to them. 8. Interview on 12/11/25 at 4:04 p.m. with regional nurse consultant D revealed: *She agreed that the baseline care plan should be reviewed with the resident and documented that it was reviewed. *She would expect the baseline care plan to be resident-centered.	F0655		01.25.26

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F0655 SS = F	Continued from page 20 *She expected the baseline care plan to be completed and reviewed with the resident or resident representative within 48 to 72 hours after the resident was admitted to the facility. *She expected the information in the baseline care plan to be accurate and provide a basis of information that would allow for the staff to provide safe resident-centered care. *She expected each resident to be involved in discharge planning, and the baseline care plan was to identify what the resident's discharge goals were. 9. Review of the providers May 2025 Care Plan policy revealed: **Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay." **Each resident is an individual. 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. **Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death." **The director of nursing [DON] will be responsible for holding the team accountable to initiating and completing the admission care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter." **Interventions act as the means to meet the individual's needs. The "recipe" for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met." **Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing." **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 than 48 hours after admission. Nursing, dietary, activities and social services staff complete formal assessments, interviews and observation	F0655		01.25.26

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F0655 SS = F	Continued from page 21 and begin formulating the full care plan as soon after admission as possible. (These departments do have areas that need to be completed by the 48 hour deadline)." **The areas that must be addressed in the baseline care plan include the minimum healthcare information necessary to properly care for a resident including but not limited to; initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendation, if applicable." Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure their policy was followed for: *Medication administration documentation for four of four sampled residents (18, 20, 23, and 34) with physician's orders for antifungal powder according to the provider's policy. *Implemented for one of one resident (5) who had physician-ordered speech services. Findings include: 1. Observation in resident 23's bathroom on 12/9/25 at 10:20 a.m. revealed: *One open bottle of Miconazole 2% powder (a medicated powder used to prevent fungal growth on skin) on the shelf. The bottle had resident 23's first name and last initial handwritten on it. There was no pharmacy label on that bottle. *This bathroom was shared between 4 residents. 2. Observation and interview on 12/10/25 at 2:42 p.m. with resident 18 in her room revealed:	F0655 F0658		01.25.26

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F0658 SS = D	Continued from page 22 *She had an open bottle of miconazole powder in the drawer of her nightstand. This did not have a resident name handwritten on it or a pharmacy label on it. *The CNA's would put that powder on her when she used the bathroom. 3. Interview on 12/10/25 at 2:57 p.m. with CNA M revealed: *The nurses get creams and powders out of the medication room if a resident needed them. *They had a daily huddle meeting and the CNA's were told to apply creams from the nurses in those meetings. *She tried to be "proactive" and would apply creams and powders to the residents to prevent moisture in the resident's skin folds. *She did not document that that in the residents' medication administration records (MAR). *She stated that "sometimes" the nurses would ask the CNAs to apply topical creams and powders. "Sometimes" the CNAs will apply those items and then tell the nurse they applied them. 4. Interview on 12/11/25 at 4:15 p.m. with regional nurse consultant D revealed: *She agreed that the individual who applied the medicated powder should be the individual to document it in the resident's MAR. *She agreed that having multiple bottles in the residents' shared bathroom created the potential for not using the correct individual residents' products. *She stated that the nurses should not be documenting in the MAR that they gave a medication if they did not administer it or after they instructed a CNA to apply it. 5. Review of resident 18, 20, 23, and 34's EMR revealed: *The physician's order for the Miconazole 2% powder had instructions to "apply to intertriginous [areas where skin rubs together and the friction creates moisture	F0658	1.Immediate corrective action for residents 18, 20, 23, &34 Miconazole 2% Powder was removed from residents' rooms/ bathrooms. A full house audit was conducted on 01.05.26. Resident 5- Physician's order dated 4/7/25 included PT-OT-ST. PT-OT were completed. The Reliant Rehab therapy team did not reach out to speech therapist to conduct the speech evaluation. Immediate intervention-Fax was sent to doctor requesting speech orders on 12.10.25-received signed doctor's order for speech on 12.11.25-resident evaluated by speech on 12.16.25. 2.All residents have the potential to be at risk. The DON/ADON will in-service nursing team members on medication administration and the facility policy "Following Physician's Orders" no later than 01.25.26, or prior to a team member's next worked shift. 3.The Director of Nursing (DON) or designee will conduct room audits of 8 residents' rooms/bathrooms each week to ensure compliance. The Director of Nursing (DON) or designee will also review any new therapy orders each week for residents to ensure compliance. The audit will be weekly for 4 weeks then monthly for 2 months. Results will be reviewed and discussed by the Director of Nursing (DON) or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0658 SS = D	Continued from page 23 and fungal growth] areas two times per day". "Residents 18, 29, 23, and 34 did not have physician's orders to self-administer the Miconazole 2% powder. 6. Review of the provider's 5/20/22 CNA job description revealed the CNAs were expected to: *"performs various tasks assigned by the floor nurse". *"completes medical records documenting care provided". 7. Review of the provider's December 2019 Medication Administration – General Guidelines policy revealed: *"Medications are prepared only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to prepare and administer medications." *"The person who prepares the dose for administration is the person who administers the dose." *"Residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications." *"The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given." 8. Observation and interview on 12/9/25 at 9:24 a.m. with resident 5 in his room revealed: *His clothes appeared to be too big for him. *He was hard of hearing and did not respond to questions. *He looked at his watch, said it was 9:30, and then stated, "I don't know but think it is night." 9. Review of resident 5's electronic medical record (EMR) revealed: *He was admitted on 5/12/23. *His 10/7/25 Brief Interview of Mental Status assessment score was a 4, which indicated his cognition	F0658		01.25.26

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F0658 SS = D	Continued from page 24 was severely impaired. *His diagnoses included: Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dysphagia (difficulty or discomfort in swallowing food or liquids, potentially leading to serious complications like aspiration pneumonia), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and need for assistance with personal cares. *He was hospitalized from 4/4/25 to 4/7/25 for aspiration pneumonia (an upper respiratory infection). *There was a 4/7/25 physician order for speech therapy services. 10. Interview on 12/10/25 at 11:36 a.m. with regional nurse consultant (RNC) D regarding resident 5's 4/7/25 physician-ordered speech therapy, revealed that there were no documented speech therapy evaluations or treatments for resident 5. 11. Follow-up interview on 12/10/2025 at 1:50 p.m. with RNC D regarding resident 5's 4/7/25 physician-ordered speech therapy revealed that she had visited with the provider's therapy department, and resident 5 had not received speech therapy services. 12. Review of the provider's 11/18/25 Following Physician Orders revealed "All physician orders should be followed as written. The prescriber should be contacted if any order is not clear/understood. The physician should be notified when an order is not followed for any reason (omission, medication not in stock, repeated resident refusals for medication/treatments, etc.). 13. Interview and review of the providers' above policy regarding following the physician's orders on 12/11/25 at 1:41 p.m. with RNC D revealed that the staff did not follow that policy related to resident 5's 4/7/25 physician's order for speech therapy.	F0658		01.25.26
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4)	F0700		01.25.26

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F0700 SS = D	Continued from page 25 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents (1 and 17) who used side rails (bars attached to the bed) had documented alternatives attempted prior to the implementation of using those side rails and the risks and benefits of using those side rails were reviewed with the resident or the resident's representative. Findings include: 1. Observation and interview on 12/09/25 at 9:35 a.m. of resident 17's room revealed: *There were two quarter-length side rails in the up position at the head of her bed. *She used the side rails to change position herself in bed and to help transfer herself in and out of bed. Review of resident 17's electronic medical record (EMR) revealed: *She was admitted on 10/6/25. *Her 10/21/25 Brief Interview of Mental Status (BIMS)	F0700		01.25.26

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F0700 SS = D	Continued from page 26 assessment score of 15, indicated her cognition was intact. *A 10/15/25 physician's order for, "Enabler bars [side rails] in [on] both sides of [her] bed to help [her] with repositioning." *Her 10/15/25 Side rail/Other Device Evaluation assessment indicated she requested the side rail, "so that she is able to reposition self [herself] and also [to] help staff." -The check box in front of the "Select any/all alternatives that have been attempted" was "Other" and within the "Specify other alterative(s)" "Enabler bars on both sides of bed" was documented as the intervention attempted prior to the installation of the side rails. -The assessment did not include if any alternatives were attempted prior to the implementation of those side rails. -Resident 17 gave consent for the installation of the side rails on 10/15/25 at 3:45 p.m. -There was no documentation of what the risks and benefits of the side were or if the risk and benefits were reviewed with resident 17 prior to her consent for the installation of the side rails. 2. Observation on 12/9/25 at 4:00 p.m. of resident 1's room revealed two quarter-length side rails in the up position at the head of his bed. Review of resident 1's EMR revealed: *He was admitted on 10/17/25 *His 10/25/25 BIMS assessment score was 13, which indicated his cognition was intact. *A 10/20/25 physician's order for, "Bilateral enabler bars on the bed to help with repositioning for [the] resident." *His 10/17/25 Side rail/Other Device Evaluation assessment indicated he requested the side rail, "so that he is able to reposition [himself] when in bed." -The check box in front of the "Select any/all alternatives that have been attempted" was "Other" and within the "Specify other alterative(s)" "enabler bars" was documented as the intervention attempted prior to	F0700	1.Resident 17-No Corrective action needed as the informed consent and risk vs. benefits was was completed on 10.15.25 and uploaded to system. Resident 1-No corrective action needed as the informed consent and risk vs. benefits was was completed on 10.15.25 and uploaded to system. No immediate corrective action for alternative devices could be completed as enabler bars were already installed on beds. 2.All residents have the potential to be at risk. The DON/ADON will in-service all licensed nursing team members on completing Device UDA entirely or completely and alternatives attempted prior to implementing enabler bars no later than 01.25.26. 3.The Director of Nursing (DON) or designee will review all new requests for enable bars each week.The audit will be weekly for 4 weeks then monthly for 2 months.Results will be reviewed and discussed by the Director of Nursing (DON) or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0700 SS = D	Continued from page 27 the installation of the side rails. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -Resident 1's resident representative gave consent for the installation of the side rail on 10/17/25 at 1:00 p.m. -There was no documentation of what the risks and benefits of the side were or if the risks and benefits were reviewed with resident 1 or his representative prior to his representative giving consent for the installation of those side rails. 3. Interview on 12/10/25 at 2:46 p.m. with licensed practical nurse (LPN) I revealed: *If a resident would request side rails, or if a staff member would think a resident would benefit from a side rail the nurse would request a physician's order for the use of a side rail. *When the physician's order for the side rail was received the nurse would complete the Side rail/Other Device Evaluation assessment. *A request would then be made for maintenance to install the side rails on the resident's bed. *The interdisciplinary team (IDT) would discuss the potential for the installation of side rails on a resident's bed and determine if there was an alternative that could be attempted before the side rails were implemented. *Therapy was involved with some residents when a side rail was requested or recommended. *Not all residents who requested a side rail or were suggested to use a side rail by a staff member, had alternatives attempted prior to the installation of the side rail *LPN I stated the nurses would obtain consent from the resident or the resident's representative when completing the Side rail/Other Device Evaluation assessment. *She verified the resident's risks and benefits for the use of a side rail was not included in the Side rail/Other Device Evaluation assessment.	F0700		01.25.26

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F0700 SS = D	Continued from page 28 4. Interview on 12/11/25 at 4:21 p.m. with regional nurse consultant D revealed: *The provider did not have a policy related to the side rails if the side rails were not determined to be a restraint. *She stated the resident or resident's representative would give consent for the use of the side rails and the review of the risks versus benefits of the side rails would be part of the consent process. *She did not know if the provider attempted any alternatives prior to the installation of the side rails or where that would have been documented.	F0700		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure medications for four of four sampled residents (18, 20, 23, and 34) with physician's orders for antifungal	F0761		01.25.26

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F0761 SS = E	Continued from page 29 powder were labeled and stored according to the provider's policy. Findings include: 1. Observation in resident 23's bathroom on 12/9/25 at 10:20 a.m. revealed: *One open bottle of Miconazole 2% powder (a medicated powder used to prevent fungal growth on skin) on the shelf. The bottle had resident 23's first name and last initial handwritten on it. There was no pharmacy label on that bottle. *The bathroom is shared between four residents. 2. Observation and interview on 12/10/25 at 2:42 p.m. with resident 18 in her room revealed: *She had an open bottle of miconazole powder in the drawer of her nightstand. This did not have a resident name handwritten on it or a pharmacy label on it. *The CNAs put that powder on her when she used the bathroom. 3. Interview on 12/10/25 at 2:57 p.m. with CNA M revealed: *The nurses get creams and powders out of the medication room if a resident needed them. *They are typically stored in the resident's bathroom. *They had a daily huddle meeting and the CNAs were told to apply creams from the nurses in those meetings. *She tries to be "proactive" and would apply creams and powders to the residents to prevent moisture in the resident's skin folds. *She did not document that in the residents' MAR. *She stated that "sometimes" the nurses would ask the CNAs to apply topical creams and powders. "Sometimes" the CNAs would apply those items and then tell the nurse they applied them. 4. Interview on 12/11/25 at 4:15 p.m. with regional nurse consultant D revealed:	F0761	1.Immediate corrective action for residents 18, 20, 23, &34 Miconazole 2% Powder was removed from residents' rooms/ bathrooms. A full house audit was conducted on 01.05.26. 2.All residents have the potential to be at risk. The DON/ADON will in-service nursing team members on medication administration and the facility policy "Following Physician's Orders" no later than 01.25.26. or prior to a team member's next worked shift. 3.The Director of Nursing (DON) or designee will conduct room audits of 8 residents' rooms/bathrooms each week to ensure compliance. The audit will be weekly for 4 weeks then monthly for 2 months. Results will be reviewed and discussed by the Director of Nursing (DON) or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0761 SS = E	Continued from page 30 *She agreed that having multiple bottles in the residents' shared bathroom created the potential for not using the correct individual residents' products. *She agreed that the individual that applied the medicated powder should be the individual to document it in the resident's MAR. *She stated that the nurses should not be documenting in the MAR that they gave a medication if they did not administer it or after they instructed the CNA to apply it. 5. Review of resident 18, 20, 23, and 34's EMR revealed: *The physician's order for the Miconazole 2% powder had instructions to "apply to intertriginous [areas where skin rubs together and the friction creates moisture and fungal growth] areas two times per day". *Resident 18, 29, 23, and 34 did not have physician's orders to self-administer the Miconazole 2% powder. Review of the provider's January 2018 Medication Storage in the Facility policy revealed: *"Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) [are] permitted access to medications." *"Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart."	F0761		
F0803 SS = D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F0803		01.25.26

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F0803 SS = D	Continued from page 31 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two sampled residents (19 and 35), who received an altered texture therapeutic diet of pureed food, received the required nutritional value and the required amount of pureed food served to them. Findings include: 1. Observation and interview on 12/9/25 at 11:10 a.m. with cook Q revealed that pureed broccoli was prepared with water. Cook Q stated the cooks were trained that pureeing broccoli with water was appropriate. She reported that she often used water to puree vegetables and used broth as the liquid to puree other foods. Cook Q agreed that using water to puree vegetables would reduce the nutritional value of the vegetables. Observation on 12/9/25 at 11:43 a.m. of cook R in the kitchen revealed cook R dished the pureed food items by pouring the food from a pan without using a scoop to measure the amounts of those foods. Review of resident 19's electronic medical record (EMR) revealed a physician-ordered diet of puree texture.	F0803	1.Residents 19 &35 no immediate corrective action could be completed. Cook Q was provided correction on the company policy Pureed Food Preparation and Cook R was provided correction on the proper way to measure pureed food when serving residents on 12.9.25. 2.All residents have the potential to be at risk. The CDM will in-service all dietary team members on the Pureed Preparation Policy no later than 01.25.26, or prior to a dietary team member's next worked shift. 3.The Admin or designee will audit weekly the preparation and measuring of residents with a pureed diet. The audit will be weekly for 4 weeks then monthly for 2 months.Results will be reviewed and discussed by the Admin or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	0125.26

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0803 SS = D	Continued from page 32 Review of resident 35's EMR revealed a physician-ordered diet of puree texture. Interview on 12/11/2025 at 12:14 p.m. with certified dietary manager (CDM) F regarding pureed food revealed: *The proper serving of pureed foods included the use of the correct-sized scoop according to what was listed on the menu spreadsheet, and pureed foods were not to be poured from a pan without measuring. *There was a color-coded instruction sheet posted in the kitchen that indicated the scoop size to be used when serving foods. *Foods were to be pureed with a liquid that contained nutritional value. -Water had no nutritional value and should not be used to puree food. Review of the provider's 2020 Pureed Food Preparation policy revealed: **"Pureed foods will be prepared using standardized recipes to ensure quality, flavor, palatability, and maximum nutritive value." **"Recipes will not use water to thin pursed foods. Only broth, milk, juice, gravy, margarine or another appropriate condiment that preserves flavor shall be used." **"Serve with appropriate scoop number or divide equally to provide an equal number of portions. All the pureed food must be used in order to deliver the correct nutrient density to each resident. Review of the provider's 2020 Menu Diet Spreadsheets/Portion Serving Communication Tool revealed: **"Diet spreadsheets are based on the planned menu and reflect serving portions for regular and therapeutic diet orders offered in the community." **"Diet spreadsheets are dated for each day of the menu cycle and are reviewed and approved by the registered dietitian.	F0803		0125.26

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F0803 SS = D	Continued from page 33 Interview on 12/11/25 at 2:34 p.m. with regional nurse consultant D regarding serving of pureed food revealed: *A scoop was to be used for measuring the amount of pureed food to be provided to each resident on a therapeutic pureed diet. *Water had no nutritional value. *She confirmed the provider's policies regarding Pureed Food Preparation and Menu Diet Spreadsheets/Portion Serving Communication were not followed by cooks Q and R.	F0803		
F0812 SS = D	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, and policy review, the provider failed to ensure food safety standards were followed by three of three employees (certified nursing assistant (L), guest services aide (GSA)/cook R, and cook Q), completed proper hand hygiene during one of one meal service.	F0812		01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

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F0812 SS = D	Continued from page 34 Findings include: Based on observation, interview, and policy review, the provider failed to ensure three of three employees (certified nursing assistant (L), guest services aide (GSA)/cook R, and cook Q), completed proper hand hygiene during one of one meal service. Findings include: 1. Observation on 12/9/25 between 11:14 a.m. and 11:58 a.m. in the provider's dining room revealed: *Resident 7 was one of the first to arrive in the dining room at 11:19 a.m. She was the second to last resident to be served lunch at 11:58 a.m. *Certified nurse assistant [CNA] L sat down at the dining table at 11:47 a.m. between residents 24 and 26. -She grabbed the front handrails of resident 24's wheelchair. She pulled the resident closer to the table. -She turned to resident 26 and pulled resident 26's wheelchair closer to the table. -She did not perform hand hygiene between touching both residents' wheelchairs. Continued observation on 12/9/25 at 11:52 a.m. revealed: *CNA L was feeding resident 24 a bite of food. *She turned to resident 26 and provided that resident a bite of food with the same hand. *She did not perform hand hygiene between feeding the residents with the same hand. 2. Review of the providers' May 2025 Hand Hygiene policy revealed: *"Hand hygiene" refers to a general term that applied to hand washing, antiseptic handwash, and ABHR [alcohol based hand rub]. *"Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial	F0812	1.No immediate corrective action could be completed for CNA L sitting with residents 24&26. Cook R was provided correction by surveyor on 12.9.25-Cook Q was also provided correction by surveyor on 12.9.25. 2.All residents have the potential to be at risk. The CDM will in-service all dietary and nursing team members on the facility Handwashing and Glove Use Policy no later than 01.25.26, or prior to a team member's next worked shift. All team members will also be in-serviced on this policy no later than 01.25.26, or prior to their next worked shift. 3.The CDM or designee will audit weekly the proper use of gloves and proper hand washing techniques The audit will be weekly for 4 weeks then monthly for 2 months.Results will be reviewed and discussed by the CDM or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0812 SS = D	Continued from page 35 soap and water under the following conditions.....before and after eating or handling food". "The preferred methos of hand hygiene is with ABHR for the following situations: -"Before and after direct contact with residents -After contact with the resident's intact skin -After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident." 3. Observation and interview on 12/9/25 at 11:30 a.m. of meal service revealed: *Guest Services Aide (GSA)/cook R was wearing one-use gloves. -With those gloves, she served chicken teriyaki, fried rice, broccoli, and egg rolls with different utensils. -She then picked up a slice of bread with a pair of tongs and placed it on the plate next to the above food items. -With those same gloved hands, she took a lid off a pan that was in the steam table, took a cheeseburger on a bun that was wrapped in tinfoil from that pan, removed the tinfoil, picked up the cheeseburger bun with the same gloves on, and placed it on a plate. -GSC/cook R completed this routine two more times. -GSC/Cook R confirmed she had used tongs for bread, but not for the cheeseburger in a bun. *She agreed she had potentially contaminated her one-use gloves by touching utensils, tinfoil, and a pan lid before touching the cheeseburger bun. 4. Observation and interview on 12/9/25 at 11:43 a.m. with cook Q revealed: *She had on a one-use glove on one hand, there was no glove on her other hand. *She took a bag of hot dog buns, opened it with both hands, reached into the bag, and took out a hot dog bun with her gloved hand. *Cook Q confirmed she was not aware of all the	F0812		0125.26

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F0812 SS = D	Continued from page 36 locations the hotdog bun bag had been before she opened it. -She agreed she had potentially contaminated her one-use gloved hand by touching the hot dog bag, opening it with both hands, and then touching a hot dog bun with her gloved hand. 5. Review of the provider's 2020 Handwashing and Glove Use policy revealed: *Policy: "Guidelines for handwashing and glove use to promote safe and sanitary conditions throughout the Food and Nutrition Services Department must be followed." *Gloves: -"Gloves may be used for one task only." -"It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands." 6. Interview on 12/11/2025 at 12:14 p.m. with certified dietary manager (CDM) F revealed: *Ready-to-eat food, such as buns, should not be touched with potentially contaminated gloves or ungloved hands. *The provider's process was to use gloves for one task only. *She confirmed GSA/cook R and cook Q had not followed the provider's policy for glove use. 7. Interview on 12/11/25 at 2:34 p.m. with regional nurse consultant (RNC) D stated that she expected staff members to avoid touching food with gloved or ungloved hands that could be potentially contaminated.	F0812		0125.26
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of	F0880		01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F0880 SS = E	Continued from page 37 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 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.	F0880		0125.26

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F0880 SS = E	Continued from page 38 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure standard infection control practices were followed by: *One of one certified nursing assistant (CNA) (L) performed hand hygiene while assisting residents during their dining experience. *One of one CNA (K) performed hand hygiene (handwashing) before putting on gloves and after removing his gloves. *One of one CNA (P) wore personal protective equipment (PPE) (such as a gown and gloves) while providing cares for a resident (4) on contact precautions (a gown and glove were to be worn anytime there was a risk of contact with a resident or objects he may have been in contact with). *Two of two CNAs (K and P) adequately cleaned and disinfected the shower room with a hospital grade disinfectant between residents' showers in two of two shower rooms. Findings include: 1. Observation on 12/9/25 between 11:14 a.m. and 11:58 a.m. in the provider's dining room revealed: *Certified nurse assistant [CNA] L sat down at the dining table at 11:47 a.m. between residents 24 and 26. -She grabbed the front handrails of resident 24's wheelchair. She pulled the resident closer to the	F0880	1. No immediate corrective action could be completed for residents 24,26,37,4. 2. All residents have the potential to be at risk. Fabuloso cleaner has been removed from shower rooms.Laudry basket has been disinfected.The Director of Nursing (DON) or designee will provide education to all staff on the Hand Hygiene Policy, Transmission-Based Precautions Policy, Enhanced Barrier Precautions Policy and Disinfection of Equipment Policy no later than 01.25.26. 3. The Director of Nursing (DON) or designee will conduct ongoing audits to monitor compliance with infection prevention practices. This includes:Completion of 5 direct observations of staff entering rooms under Transmission-Based Precautions or Enhanced Barrier Precautions to ensure proper donning and doffing of appropriate personal protective equipment (PPE) Completion of 5 hand hygiene observations to verify staff perform hand hygiene at appropriate times and in accordance with facility policy.Completion of five (5) observations of cleaning and disinfecting shower rooms to ensure staff follow facility policy, use approved disinfectants, and clean high-touch surfaces appropriately between resident use. Audits will be conducted weekly for four (4) weeks, followed by monthly audits for an additional two (2) months. Results will be reviewed and discussed by the DON or designee during the monthly QAPI meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and determination of next steps, including continuation, revision, or discontinuation of audits based on findings.	01.25.26

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F0880 SS = E	Continued from page 39 table. -She turned to resident 26 and pulled resident 26's wheelchair closer to the table. -She did not perform hand hygiene between touching both residents wheelchairs. Continued observation on 12/9/25 at 11:52 a.m. revealed: *CNA L was feeding resident 24 a bite of food. *She turned to resident 26 and provided that other resident a bite of food with the same hand. *She did not perform hand hygiene between feeding the residents with the same hand. 2. Observation on 12/11/25 at 9:52 a.m. of the 100-hall tub room revealed: *In the tub room was a spray bottle of Fabuloso 2x lavender bottle (a household cleaner) and a bottle of Medline Micro-Kill Q3 (a hospital grade disinfectant) on the shelf in the shower. -The Fabuloso was purple in color. *On the inside of the cover of the white laundry basket was a brown smear, and the interior seams of the laundry basket had a dense line of a brown substance on it. *The bucket for under the shower chair had a purple liquid in it. *The seat of the shower chair was wet. *The surrounding walls of the back portion of the shower area were dry. 3. Interview on 12/11/25 at 9:58 a.m. with CNA O revealed: *The Fabuloso 2X was used by the night staff to clean the floor of the tub room. *She used the Micro-Kill disinfectant to spray the shower after she finished showering a resident. She let the Micro-Kill sit on the surface until just before she showered another resident when she would rinse off the	F0880		01.25.26

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F0880 SS = E	Continued from page 40 surfaces of the shower. 4. Observation and interview on 12/11/25 at 10:32 a.m. with CNA J in the 300-hall shower room revealed: *There were two shower rooms in the facility in the 100 and 300 hallways. *The 100-hall tub room had a bathtub and shower in it, but the 300-hallway shower room only had a shower. *The 300-hall shower room did not get used often. *There was a bottle labeled with the Fabuloso 2X label with a clear colored cloudy liquid. *There was not a bottle of Micro-Kill in the 300-shower room. 5. Interview on 12/11/25 at 12:09 p.m. with nurse consultant D revealed: *She had spoken with the administrator about the Micro-Kill and the Fabuloso 2X. *During the day the housekeeping staff were to use the Micro-Kill to clean the shower room and then use the Fabuloso 2X after, to make the room smell better. *The Micro-Kill was to be used on the shower chair and all the surfaces in the shower as it was a hospital grade disinfectant. *The Fabuloso was left in the shower room because at night the CNAs cleaned the resident wheelchairs with it and then washed the floors of the tub room after they cleaned the wheelchairs. 6. Observation on 12/11/25 at 1:51 p.m. of CNA P as she exited the 100-hall tub room revealed: *She was not wearing a gown or gloves. *She pushed resident 4 on a bath chair, down the hallway, and into his room. *After she pushed resident 4 into his room, she exited the room and put on a gown and gloves and reentered the room. *On the outside of resident 4's room was a sign that indicated he was on contact precautions. 7. Observation and interview on 12/11/25 at 2:00 p.m.	F0880		01.25.26

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F0880 SS = E	Continued from page 41 with CNA K in the 100-hall tub room revealed: *There was a pair of gloves in the trash can but no gown. *Resident 4's medicated shampoo and a bottle of Baby Magic Wash labeled "stock" were on the half wall that divided the shower and the rest of the room. -The bottles had water droplets on them. *CNA K pushed the shower chair that was used by resident 4 into the tub room. *He was not wearing a gown or gloves when he entered the tub room. *He applied gloves without having performed hand hygiene. *He removed the bucket from under the shower chair, sprayed the shower chair with Fabuloso 2X and then rinsed it off with water. *Sprayed the shower chair with Micro-Kill and then rinsed it off with water. *He did not spray the surrounding walls or floor of the shower with either the Fabuloso or the Micro-Kill. *CNA K confirmed the shower chair was the one used by resident 4. *He picked up a blanket that had been lying on the tub and placed it in the hamper. *He removed his gloves and did not perform hand hygiene. *He stated the bucket under the shower chair was cleaned with Fabuloso spray and then sprayed with Micro-Kill. He would let the Micro-Kill sit for a "little while" to dry and if it was not dry, he would dry it off before it was used for another resident. *CNA K did not know if either the Fabuloso or the Micro-Kill had a contact time (the specific duration cleaning/disinfecting product must remain visibly wet on a surface to effectively kill germs, clean, or achieve its intended chemical action). *He picked up the bottle of resident 4's shampoo and the Baby Magic Wash and placed it in a cabinet beside other bottles of shampoos and body washes without	F0880		01.25.26

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F0880 SS = E	Continued from page 42 cleaning the outside of the bottles. *CNA K exited the tub room and returned with resident 37 to give him a shower. 8. Interview on 12/11/25 at 2:13 p.m. with CNA P revealed: *To clean the shower, she sprayed the purple-colored cleanser on the shower chair and floor and let it sit for a couple minutes and then rinsed it off. *She stated the purple-colored cleaner had a three-minute contact time. *She did not know if the Micro-Kill had a contact time. *She verified she had not worn a gown while she showered resident 4. *She was aware she was supposed to wear a gown and gloves for resident 4's cares because he was on contact precautions. 9. Interview on 12/11/25 at 4:04 p.m. with nurse consultant D revealed: *She would expect all staff to perform hand hygiene per policy. This included when their hands or gloves were soiled, when switching between a dirty procedure and a clean procedure, between glove changes, after assisting one resident and before assisting another resident, and when assisting residents with eating. *She expected PPE to be worn while providing cares if a resident was on EBP or contact precautions. *She expected the tub and shower be cleaned with proper disinfectant between each resident's use. *She verified resident 4's medicated shampoo and the stock bottle of Baby Magic Wash should have been cleaned prior to placing them back in the cabinet because there was the potential for those bottles to have been contaminated with touch or splash due to the proximity to the location in which the resident would have sat while he took a shower. 10. Review of the providers May 2025 Hand Hygiene policy revealed: *"Hand hygiene" refers to a general term that applied to hand washing, antiseptic handwash, and ABHR [alcohol based hand rub].	F0880		01.25.26

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F0880 SS = E	Continued from page 43 *"Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions.....before and after eating or handling food". *The preferred methos of hand hygiene is with ABHR for the following situations: -"Before and after direct contact with residents -After contact with the resident's intact skin -After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident." Review of the provider's 1/26/25 Transmission Based Precautions policy revealed: *"Facility will use contact precautions in addition to standard precautions for residents known or suspected to have a serious illness easily transmitted by direct resident contact or by contact with items in the resident's environment. *"Hand hygiene should be completed prior to donning [putting on] and after removal of gloves. *Gloves should be worn when entering the room and while providing care for the resident. *Gloves should be changes when contaminated (e.g. handling fecal material and wound drainage). *Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately. *After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items." *"A gown should be donned prior to entering the room or resident's cubicle. *The gown should be removed before leaving the resident's room." *"TRANSPORTATION FOR MEDICALLY NECESSARY REASONS: -When the resident leaves the room, precautions should be maintained to minimize the risk of transmission of pathogens to others and contamination of surfaces or equipment."	F0880		01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET , GROTON, South Dakota, 57445

(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
F0880 SS = E	Continued from page 44 Review of the provider's 2/25/25 Cleaning and Disinfection of Equipment policy revealed: **Cleaning refers to removal of visible soil (e.g., organic and inorganic material) from objects and surfaces and is normally accomplished manually or mechanically using water with detergents or enzymatic products. *Disinfection: refers to thermal or chemical destruction of pathogenic and other types of microorganisms." **"Device classification Noncritical (touches intact skin but not mucous membranes)". **"Devices (examples) Stethoscopes, tabletops, bedpans, etc." **"Spaulding process classification Low-level disinfection". **"Hospital disinfectant with label claim for HBV [hepatitis B virus] and HIV [human immunodeficiency virus]." Review of the 2022 Medline Micro-Kill Q3 manufacturer's instructions revealed: **"Micro-Kill Q3 is a concentrated one-step disinfectant formulated for general hospital cleaning and the disinfection of hard, nonporous, non-food surfaces." **"Three-minute contact time for many bacteria and viruses." Review of the Fabuloso manufacturer's information indicted it was a household cleaner that killed most viruses and bacteria but was not considered a hospital grade disinfectant because it was not indicated to kill HBV or HIV.	F0880		01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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E0000	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 12/10/25. Avantara Groton was found in compliance.	E0000		01.25.26

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda	LNHA	01.09.26

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - MAIN BUILDING 0... B. WING	12/10/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 12/10/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Groton was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0222 SS = D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is	K0222		01.25.26

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda	LNHA	01.09.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0222 SS = D	Continued from page 1 protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to provide egress doors as required at one of five locations (300 wing exterior door). Findings include: 1. Observation on 12/10/25 at 11:00 a.m. revealed the exterior EXIT door for the 300 wing was equipped with a magnetic lock that prevented egress. The door was labeled as a delayed egress locked door. Testing of the door by applying force to the panic hardware in the direction of the path of egress revealed the audible signal would sound, but the required irreversible process of unlocking the door did	K0222	1. All residents are at risk. The fire EXIT door cited in the deficiency on 12.10.25 for the 300 wing was repaired by Automatic Door Doctor on 1.07.26. 2. Administrator will in-service maintenance director by 01.25.26 to ensure the facility follows the NFPA 101 Egress Doors. 3. The Administrator or designee will complete weekly audits to make sure the fire EXITS labeled as delayed egress are operating per regulations Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.1(3) . Results of the audit will be reported by Administrator or designee in the monthly QAPI Meetings for further review and recommendation and/or continuance of audits.	01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0222 SS = D	Continued from page 2 not initiate as required after the pressure on the door was stopped. Interview with the maintenance director at the time of the observation and testing confirmed that condition. He revealed the magnetic lock would release in fifteen seconds if constant pressure was applied to the door. Failure to provide egress doors as required increases the risk of death or injury due to fire or other emergencies. The deficiency affected one of five marked EXIT doors with delayed egress magnetic lock labelling. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.1(3)	K0222		
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K0918		01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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K0918 SS = D Bldg. 01	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to maintain the diesel generator as required (monthly load testing documentation, monthly battery conductivity testing, and annual load banking). Findings include: 1. Document review on 12/10/25 at 11:30 a.m. revealed the generator monthly required maintenance was performed by Butler Cat Company. That maintenance included load runs and battery conductivity testing. The dates of service were documented as completed from December 2024 through December 10, 2025 on: *12/30/24. *1/24/25. *2/24/25. *3/24/25. *4/22/25. *5/20/25. *7/31/25. *9/2/25. *10/30/25. *11/24/25. There was no documentation for June 2025 or August 2025, with nearly a two-month gap between May 2025 and July 2025 and between September 2025 and October 2025. There was no documentation of load run testing and related hour meter readings including cool-down times. The lack of monthly 30-minute load run testing over 30 percent of the generator's nameplate value require a load bank to be performed. The last load bank performed on the generator was documented as completed on 12/6/24. Interview with the maintenance director at the time of the document review confirmed those findings. He revealed he was a new employee to the provider in the past year. The deficiency affected three of numerous requirements for diesel generator maintenance.	K0918	1 All residents are at risk. No corrective action could be completed. 2. The Administrator will in-service the Maintenance Director by 01.25.26 to ensure Butler Cat Company runs the required monthly load runs and battery conductivity testing. 3. The Administrator or designee will complete monthly audits for 4 months to ensure Butler Cat Company performs the required monthly load runs and batter conductivity testing per regulations 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). Results of the audit will be reported by Administrator or designee in the monthly QAPI Meetings for further review and recommendation and/or continuance of audits.	01.25.26

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K0918 SS = D Bldg. 01		K0918		

South Dakota Department of Health

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	10626	A. BUILDING: _____ B. WING _____	12/11/2025

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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 12/9/25 through 12/11/25. Avantara Groton was found not in compliance with the following requirements: S157 and S236.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation 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, testing, and interview, the provider failed to ensure three of five storage rooms (janitor's closet in front of the boiler room, soiled linen holding room in laundry, and the housekeeping closet in 200 wing) were equipped with working exhaust ventilation. Findings include: 1. Observation on 12/10/25 at 10:25 a.m. of the janitor's closet by the boiler room revealed it was equipped with exhaust ductwork. Testing of the exhaust grille at the time of the observation revealed the exhaust was not working. Observation on 12/10/25 at 10:35 a.m. of the main laundry soiled holding room revealed it was equipped with exhaust ductwork. Testing of the exhaust switch at the time of the observation revealed the exhaust fan was not working.	S 157	1. All residents are at risk. Immediate corrective action. Allied Climate Professionals was contacted on 1.02.26. 01.08.26 Allied Climate Professionals determined a motor was out on the ventilation system. A part has been ordered for replacement. 2. Administrator will in-service maintenance director by 01.25.26 to ensure all five storage rooms have working exhaust ventilation. This would include the following: janitor's closet in the front of the boiler room, soiled linen holding room in laundry, and the housekeeping closet in 200 wing. 3. The Administrator or designee will complete weekly audits to make sure the all rooms with exhaust ductwork have working exhaust fans. Results of the audit will be reported by Administrator or designee in the monthly QAPI Meetings for further review and recommendation and/or continuance of audits.	01.25.26

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S 157	Continued From page 1 3. Observation on 12/10/25 at 10:45 a.m. of the housekeeping closet in the 200 wing revealed it was equipped with exhaust ductwork. Testing of the exhaust grille at the time of the observation revealed the exhaust was not working. 3. Interview with the maintenance director at the times of the testing confirmed those findings.	S 157		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood	S 236	1. All residents are at risk. Initial TB training is in the West Onboarding module for new hires. 2. Immediate corrective action annual TB training added to online curriculum beginning in January 2026. 3. The Administrator or designee will complete an audit at the end of January to ensure all current team members have completed the annual TB training. Administrator or designee in the monthly QAPI Meetings for further review and recommendation and/or continuance of audits.	01.25.26

South Dakota Department of Health

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assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;

This Administrative Rule of South Dakota is not met as evidenced by:
Based on employee personnel training record review, and interview, the provider failed to ensure personnel had completed the required annual tuberculosis (TB) (a serious infection that primarily affects the lungs that is spread through the air by coughs and sneezes) training for five of five sampled employees (G, L, Q, R, and S). Findings include:

1. Review of employee personnel records revealed:
*Employee G was hired on 6/17/25.
*Employee L was hired on 3/24/24.
*Employee Q was hired on 12/10/24.
*Employee R was hired on 11/11/25.
*Employee S was hired on 5/13/25.

2. Review of employee training records revealed, there was no documentation that employees G, L, Q, R, and S had received annual training on TB signs and symptoms, risk factors, and TB infection control policies and procedures.

3. Interview on 12/11/25 at 8:10 a.m. with regional nurse consultant D revealed:
*The provider used an online training program for employee-required training.
*The TB education was not included in the

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S 236	Continued From page 3	S 236		

infection control training as she had stated previously.
*Employees G, L, Q, R, and S had not been assigned the online TB education.

4. Continued interview on 12/11/25 at 4:38 p.m. with regional nurse consultant D revealed:
*Personnel training could be assigned at the corporate level or at the facility level.
*The required TB education had not been assigned for all staff to complete.
*Regional nurse consultant D was not aware annual TB education was a state required training.

South Dakota Department of Health

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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 12/9/25 through 12/11/25. Avantara Groton was found not in compliance with the following requirements: S157 and S236.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation 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, testing, and interview, the provider failed to ensure three of five storage rooms (janitor's closet in front of the boiler room, soiled linen holding room in laundry, and the housekeeping closet in 200 wing) were equipped with working exhaust ventilation. Findings include: 1. Observation on 12/10/25 at 10:25 a.m. of the janitor's closet by the boiler room revealed it was equipped with exhaust ductwork. Testing of the exhaust grille at the time of the observation revealed the exhaust was not working. Observation on 12/10/25 at 10:35 a.m. of the main laundry soiled holding room revealed it was equipped with exhaust ductwork. Testing of the exhaust switch at the time of the observation revealed the exhaust fan was not working.	S 157	1. All residents are at risk. Immediate corrective action. Allied Climate Professionals was contacted on 1.02.26. 01.08.26 Allied Climate Professionals determined a motor was out on the ventilation system. A part has been ordered for replacement. 2. Administrator will in-service maintenance director by 01.25.26 to ensure all five storage rooms have working exhaust ventilation. This would include the following: janitor's closet in the front of the boiler room, soiled linen holding room in laundry, and the housekeeping closet in 200 wing. 3. The Administrator or designee will complete weekly audits to make sure the all rooms with exhaust ductwork have working exhaust fans. Results of the audit will be reported by Administrator or designee in the monthly QAPI Meetings for further review and recommendation and/or continuance of audits.	01.25.26

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

Brenda Carda | LNHA | 01.14.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10626	A. BUILDING: _____ B. WING _____	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 N 2ND ST GROTON, SD 57445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 157	Continued From page 1 3. Observation on 12/10/25 at 10:45 a.m. of the housekeeping closet in the 200 wing revealed it was equipped with exhaust ductwork. Testing of the exhaust grille at the time of the observation revealed the exhaust was not working. 3. Interview with the maintenance director at the times of the testing confirmed those findings.	S 157		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood	S 236	1. All residents are at risk. Initial TB training is in the West Onboarding module for new hires. 2. Immediate corrective action annual TB training added to online curriculum beginning in January 2026. 3. The Administrator or designee will complete an audit at the end of January to ensure all current team members have completed the annual TB training. Administrator or designee in the monthly QAPI Meetings for further review and recommendation and/or continuance of audits.	01.25.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVANTARA GROTON	1106 N 2ND ST GROTON, SD 57445

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S 236	Continued From page 2	S 236		01.25.26

assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;

This Administrative Rule of South Dakota is not met as evidenced by:
Based on employee personnel training record review, and interview, the provider failed to ensure personnel had completed the required annual tuberculosis (TB) (a serious infection that primarily affects the lungs that is spread through the air by coughs and sneezes) training for five of five sampled employees (G, L, Q, R, and S). Findings include:

1. Review of employee personnel records revealed:
*Employee G was hired on 6/17/25.
*Employee L was hired on 3/24/24.
*Employee Q was hired on 12/10/24.
*Employee R was hired on 11/11/25.
*Employee S was hired on 5/13/25.

2. Review of employee training records revealed, there was no documentation that employees G, L, Q, R, and S had received annual training on TB signs and symptoms, risk factors, and TB infection control policies and procedures.

3. Interview on 12/11/25 at 8:10 a.m. with regional nurse consultant D revealed:
*The provider used an online training program for employee-required training.
*The TB education was not included in the

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	10626	A. BUILDING: _____ B. WING _____	12/11/2025

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AVANTARA GROTON	1106 N 2ND ST GROTON, SD 57445

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S 236	Continued From page 3 infection control training as she had stated previously. *Employees G, L, Q, R, and S had not been assigned the online TB education. 4. Continued interview on 12/11/25 at 4:38 p.m. with regional nurse consultant D revealed: *Personnel training could be assigned at the corporate level or at the facility level. *The required TB education had not been assigned for all staff to complete. *Regional nurse consultant D was not aware annual TB education was a state required training.	S 236		01.25.26